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CIVIL DISTRICT COURT FOR THE PARIS OF ORLEANS  
STATE OF LOUISIANA  
DIVISION K  
NO. 96-8461, DOCKET NO. 4  
CLASS ACTION CLAIM

GLORIA SCOTT and DEANIA JACKSON, :  
Plaintiffs, :  
THE AMERICAN TOBACCO COMPANY, INC., et al., :  
Defendants. :  
Videotaped  
Deposition of:  
ALDEN G. COCKBURN, M.D.

TRANSCRIPT of testimony as taken by and  
before Cynthia L. Varney, a Shorthand Reporter and  
Notary Public of the State of Florida, at the  
Crowne Plaza Hotel, 700 North West Shore Boulevard,  
Tampa, Florida, on Thursday, October 26, 2000,  
commencing at 9:15 in the morning.

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2 1 ALDEN G. COCKBURN, M.D.,  
 2 4700 North Habana Avenue  
 3 Tampa, Florida, sworn.  
 4 DIRECT EXAMINATION BY MR. LEGER:  
 5 Q. Doctor, my name is Walter Leger, and  
 6 I'm, as you know, an attorney representing the  
 7 plaintiffs in a case in New Orleans in which you've  
 8 been retained as an expert witness. I know and  
 9 understand that you've given your deposition  
 10 several times before, and therefore I'm assuming  
 11 you kind of understand what's going on —  
 12 A. I do.  
 13 Q. — in the way of procedure and  
 14 otherwise. I'm going to ask you a series of  
 15 questions over several hours, and if you don't  
 16 understand my question, if there's any  
 17 misunderstanding, please let me know. If we're  
 18 talking over each other or otherwise, let me know,  
 19 too, and — because I assume we're going to have a  
 20 tendency to communicate at one point, and as you  
 21 know, the court reporter has got to be able to hear  
 22 us individually, and separate and apart from each  
 23 other.  
 24 I'm going to ask you, now, to state  
 25 your name and your office address, once again, for

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3 1 the record.  
 2 A. Alden George Cockburn, M.D., 4700  
 3 North Habana Avenue, Tampa, Florida 33614.  
 4 Q. And, Doctor, would you — you have  
 5 been deposed before, I understand —  
 6 A. I have.  
 7 Q. — correct? About how many times?  
 8 A. Over 15 times.  
 9 Q. Okay. Now, have you been deposed in  
 10 any other tobacco-related case, other than the  
 11 Engles case?  
 12 A. No, I haven't.  
 13 Q. Have you, in connection with tobacco  
 14 or cigarette litigation, been retained or consulted  
 15 in any other matter, other than the Engles case?  
 16 A. None.  
 17 Q. So your only association with  
 18 cigarette tobacco companies has been your  
 19 involvement as an expert witness on behalf of  
 20 tobacco companies in the Engles case and now this  
 21 case —  
 22 A. That's correct.  
 23 Q. — is that correct?  
 24 MR. WATTLEWORTH: Object to the  
 25 form.

<p>1                   MR. LEGER: What's objectionable 2 about the form? 3                   MR. WATTLEWORTH: Association with 4 the cigarette and tobacco companies. 5 BY MR. LEGER: 6                   Q. Do you not -- 7                   MR. WATTLEWORTH: He's -- 8 BY MR. LEGER: 9                   Q. Are you not here on behalf of 10 tobacco companies as an expert witness? 11                   A. Yes, but not associated with them. 12                   Q. Do you have trouble, you know -- 13 does it bother you to be suggested that you're 14 associated with the tobacco companies? 15                   A. Not particularly, no. 16                   Q. All right. Is there something about 17 the word "associated" that bothers us? I'm just 18 trying to get the -- 19                   MR. WATTLEWORTH: Well, it's 20 misleading, I mean, association with the tobacco 21 companies. It's unclear what you mean by 22 "associated with tobacco companies." I think his 23 response has clarified that, though. 24 BY MR. LEGER: 25                   Q. Okay. I mean, you're paid to be</p>	<p>6                   1 15 or so other cases that you've testified in 2 previously, can you give me an idea of what those 3 cases involved? 4                   A. Usually, independent medical 5 evaluations or an expert witness in a malpractice 6 litigation. 7                   Q. Now -- and I have read your previous 8 deposition, and I really don't want to go over that 9 area in detail, but I just want to make sure that 10 there's nothing missing from that deposition, and 11 the deposition I'm talking about is the deposition 12 you gave in the Engles case; correct? 13                   A. Correct. 14                   Q. Have you reviewed that deposition 15 recently? 16                   A. No, I haven't. 17                   Q. Have you looked at it at any time 18 since your testimony in the Engle trial? 19                   A. No, I haven't. 20                   Q. You haven't looked at it in 21 anticipation of testifying in this deposition 22 today? 23                   A. No, I haven't. 24                   Q. In that deposition, I understand 25 that you had testified in approximately 10</p>
<p>1 here by -- 2                   A. That's correct. 3                   Q. A tobacco company, right? 4                   A. That's correct. 5                   Q. Is it only one company that's paying 6 you or is it all of them? 7                   A. Just one that I know of. 8                   Q. Which company are you getting a 9 check from? 10                   A. R.J. Reynolds. 11                   Q. Okay. You think that means you're 12 not associated with them, the fact that you're not 13 getting money from them? 14                   MR. WATTLEWORTH: Object to the 15 form. 16                   MR. LEGER: Okay. What's 17 objectionable about the form? 18                   MR. WATTLEWORTH: Well, it's 19 argumentative. 20                   MR. LEGER: Okay. 21 BY MR. LEGER: 22                   Q. You can answer the question. 23                   A. I have a financial relationship with 24 R.J. Reynolds as an expert witness. 25                   Q. Okay. Now, in connection with the</p>	<p>7                   1 malpractice cases, either by deposition or 2 otherwise? 3                   A. Yes. 4                   Q. Okay. And three malpractice cases 5 were cases involving claims against you; is that 6 correct? 7                   A. That's correct. 8                   Q. The other seven were as an expert 9 witness on either -- behalf of either the plaintiff 10 or the defendant; correct? 11                   A. That's correct. 12                   Q. In most cases, you've been retained 13 and testified in connection with the defense of a 14 doctor accused of malpractice -- 15                   A. That's correct. 16                   Q. -- correct? How many of those were 17 plaintiff? 18                   A. That is that the doctor was not the 19 plaintiff? 20                   Q. That's correct, where the doctor was 21 not the plaintiff. 22                   A. About three. 23                   Q. And did you testify in any where the 24 doctor was the plaintiff? -- I mean the party 25 suing the other party.</p>

<p>1 A. Yes.</p> <p>2 Q. Okay. And what case was that, where</p> <p>3 the doctor sued someone else?</p> <p>4 A. I'm sorry. I'm confused by the</p> <p>5 legalese.</p> <p>6 Q. The term. That's what I was --</p> <p>7 that's -- right.</p> <p>8 A. No, I haven't --</p> <p>9 Q. Okay.</p> <p>10 A. -- where a doctor sued someone else,</p> <p>11 no.</p> <p>12 Q. All right. Your testimony has been</p> <p>13 on behalf of doctors --</p> <p>14 A. That's correct.</p> <p>15 Q. -- when being sued, generally?</p> <p>16 A. That's correct.</p> <p>17 Q. Otherwise, in a -- I'm sorry. Was</p> <p>18 it three cases you testified for the person suing</p> <p>19 the doctor?</p> <p>20 A. That's correct.</p> <p>21 Q. Have you since the Engle deposition,</p> <p>22 have you testified in or have you been retained or</p> <p>23 involved in any malpractice cases?</p> <p>24 A. No.</p> <p>25 Q. Since your Engles deposition, have</p>	<p>10</p> <p>12</p> <p>1 Q. Okay. I appreciate that, and I</p> <p>2 would like that information, but my question is,</p> <p>3 after the deposition, at the -- either on your own</p> <p>4 or at the request of lawyers of tobacco companies,</p> <p>5 did you do any inquiry into that case?</p> <p>6 A. No, and I don't know why I would.</p> <p>7 Q. Okay. That's what I'm wondering, if</p> <p>8 they asked you to give them information about that</p> <p>9 case.</p> <p>10 A. No.</p> <p>11 Q. Okay. Do you remember who the --</p> <p>12 the names of the lawyers that sued you?</p> <p>13 A. No.</p> <p>14 MR. LEGER: Off the record.</p> <p>15 (Discussion off the record.)</p> <p>16 BY MR. LEGER:</p> <p>17 Q. By the way, did you bring a file</p> <p>18 with you today?</p> <p>19 A. No, I didn't bring anything.</p> <p>20 Q. No? Okay.</p> <p>21 MR. LEGER: Do you have the</p> <p>22 subpoena, Christine?</p> <p>23 MS. DESUE: Mm-hmm.</p> <p>24 MR. LEGER: Do you have an extra</p> <p>25 copy?</p>
<p>1 you been involved in any cases whatsoever --</p> <p>2 A. No.</p> <p>3 Q. -- other than this one?</p> <p>4 A. None.</p> <p>5 Q. So may I assume that your testimony</p> <p>6 in the Engles deposition regarding your prior cases</p> <p>7 and prior -- and history of testifying is complete,</p> <p>8 basically --</p> <p>9 A. That's correct.</p> <p>10 Q. -- other than this case and other</p> <p>11 than testifying at the Engle trial; right?</p> <p>12 A. That's correct.</p> <p>13 Q. After your deposition in the Engles</p> <p>14 case, did you go back and try to identify who the</p> <p>15 patients were that sued you? In other words,</p> <p>16 apparently, in Engles, you didn't remember the</p> <p>17 names of two of the three patients that sued you.</p> <p>18 A. Did I go back and --</p> <p>19 Q. Yes, sir.</p> <p>20 A. Which ones are you concerned about?</p> <p>21 Q. Well, all three of them, actually.</p> <p>22 The first one, 1990 or so?</p> <p>23 A. I can certainly get you that</p> <p>24 information. I don't keep it on the top of my</p> <p>25 head.</p>	<p>11</p> <p>13</p> <p>1 BY MR. LEGER:</p> <p>2 Q. Have you been shown a copy of this</p> <p>3 notice of deposition with Exhibit A attached?</p> <p>4 A. Yes. Yes, I have.</p> <p>5 Q. When did you get that?</p> <p>6 A. I saw a copy of this yesterday.</p> <p>7 Q. Did you see it before then?</p> <p>8 A. No.</p> <p>9 Q. Okay. So at no time -- at no time</p> <p>10 did you attempt to gather information in connection</p> <p>11 with this particular document that I just showed</p> <p>12 you; correct?</p> <p>13 MR. WATTLEWORTH: Well --</p> <p>14 A. Let me read the document over. I</p> <p>15 didn't --</p> <p>16 MR. WATTLEWORTH: -- for the record,</p> <p>17 you know, we have -- he has gathered information.</p> <p>18 We've produced some of that to you already.</p> <p>19 MR. LEGER: Okay. Well, that's the</p> <p>20 problem, some of it.</p> <p>21 MR. WATTLEWORTH: I'm certain you're</p> <p>22 going to tell us in a minute here. Yeah, right.</p> <p>23 I'm sure you're going to let us know which</p> <p>24 information that is.</p> <p>25 MR. LEGER: Do you have exhibit</p>

<p>1 tags? Because I would like to mark the document  2 that the doctor is reviewing now, which is a notice  3 of deposition with Exhibit A, which, under the  4 rules of the case management order and the ruling  5 of the Special Master are deemed as if submitted as  6 a subpoena duces tecum. We're going to call that  7 Cockburn No. 1.</p> <p>8 THE DEPONENT: "Co-burn."</p> <p>9 MR. LEGER: I'm sorry.</p> <p>10 THE DEPONENT: Spelled "Cock-burn";  11 it's pronounced "Co-burn."</p> <p>12 MR. LEGER: Cockburn No. 1.</p> <p>13 MR. WATTLEWORTH: So this is 1, not  14 A?</p> <p>15 MR. LEGER: Yeah, that's right, the  16 number 1.</p> <p>17 BY MR. LEGER:</p> <p>18 Q. Now, Doctor, you just looked through  19 this document. Have you provided everything that's  20 requested in this document No. 1?</p> <p>21 A. Yes, I have.</p> <p>22 Q. Okay. And who did you provide those  23 things to?</p> <p>24 A. Mr. Wattleworth.</p> <p>25 Q. Okay. We're going to go through</p>	<p>14</p> <p>1 manuscript regarding a 25-year experience with  2 seminoma and regarding spermatocytic seminoma --  3 seminoma; correct?</p> <p>4 A. Correct.</p> <p>5 Q. You would delete the -- they are no  6 longer in preparation?</p> <p>7 A. Correct.</p> <p>8 Q. How long ago were they in  9 preparation?</p> <p>10 A. Oh, I was still pursuing them up  11 until about 1989, 1990.</p> <p>12 Q. Okay. So by 1990, there were no  13 longer any manuscripts in preparation?</p> <p>14 A. That's correct.</p> <p>15 Q. Okay. And we're going to -- just  16 for the sake of the record, we're going to attach a  17 copy of that as -- that curriculum vitae -- as  18 Cockburn No. 2, and then we're going to talk about  19 that in a little bit.</p> <p>20 You also provided what is called a  21 reliance list; is that correct, Doctor?</p> <p>22 A. That's correct.</p> <p>23 Q. And now we're talking about provided  24 that in June?</p> <p>25 A. That's correct.</p>
<p>1 this. Have you provided a -- back in June, you  2 issued a report, correct?</p> <p>3 A. I did.</p> <p>4 Q. And at that time, you provided the  5 lawyers for the tobacco companies with a curriculum  6 vitae; correct?</p> <p>7 A. I did.</p> <p>8 Q. Is there an updated version of that  9 curriculum vitae?</p> <p>10 A. There is no updated version. I  11 realized that -- it is a little dated, but  12 nothing substantially new has occurred since that  13 was written.</p> <p>14 Q. So, by "dated," you mean that the  15 curriculum vitae, even in June, was a little out of  16 date; is that correct?</p> <p>17 A. It's a little out of date, yes.</p> <p>18 Q. So there's just a little more  19 information --</p> <p>20 A. No. Actually, I would delete the  21 information on the last page. Those manuscripts  22 that were in preparation are -- I guess you could  23 consider them defunct. They didn't proceed to  24 publication.</p> <p>25 Q. Okay. On the fourth page, the</p>	<p>15</p> <p>17</p> <p>1 Q. May I show you this reliance list,  2 Doctor? And what was this document, which we're  3 going to mark as Cockburn No. 3?</p> <p>4 A. That's the bibliography used in  5 making the report.</p> <p>6 Q. Have you acquired any further  7 information or materials since that date which you  8 consider will be relied upon or important to your  9 opinions in this case since this was submitted in  10 June of --</p> <p>11 A. No.</p> <p>12 Q. -- 2000? So your entire opinions  13 are based on what's in this material; correct?</p> <p>14 A. Well, I have a fund of knowledge  15 that I bring to the subject that is well beyond  16 that which is annotated in the bibliography, yes.</p> <p>17 Q. Now, just for the sake of  18 clarification, we appear to have been provided --  19 and it's really, honestly difficult to determine,  20 but -- a few additional medical journal articles  21 that are not on this list, I believe we were  22 provided by counsel for the tobacco companies.</p> <p>23 A. Okay.</p> <p>24 Q. So did they get that from you,  25 something supplemental to this?</p>

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1 A. Well – 2 MR. WATTLEWORTH: If you – perhaps 3 if he's – I'm sorry. I'm just saying, if you have 4 those articles that you could identify to him, that 5 might assist in determining exactly how he came 6 about acquiring them. 7 BY MR. LEGER: 8 Q. I'm going to show you your article 9 regarding BTA Quantitative Assay by Casetta, and a 10 urinary – another one, a urinary BTA Stat and 11 other things, by Serretta, et al. 12 A. Mm-hmm. 13 Q. These are things that you have 14 reviewed since giving your opinion? 15 A. I wouldn't say since giving my 16 opinion. I probably read these along at the same 17 time that I prepared that. I just didn't include 18 them as part of the bibliography. 19 Q. Okay. Where did you get those 20 articles? In other words, did you go look them up 21 or were they given to you by tobacco company 22 lawyers? 23 A. I think these were given to me. 24 Q. Do you know who gave them to you? 25 A. Mr. Wattleworth.	18 1 were provided to you by lawyers for the tobacco 2 company? 3 A. That's correct. 4 Q. Okay. 5 MR. WATTLEWORTH: And those 6 being – what? – the Casetta article and – 7 MR. LEGER: Casetta and Serretta 8 articles, et al. 9 MS. DESUE: And there's two – 10 BY MR. LEGER: 11 Q. And there are two additional 12 articles, one Comparative Sensitivity of Various 13 Tests, including NMP-22, by Marta Sanchez-Carbayo, 14 and a Comparative Evaluation of Various Tests, 15 including NMP-22, by Giannopoulos, et al. Those 16 are not on your reliance list, and I'm wondering if 17 you have also seen those and were they also 18 provided to you by lawyers for the tobacco 19 companies or a lawyer for the tobacco companies? 20 A. I read this article in the Journal, 21 and I don't remember – I honestly don't remember 22 where – if I saw this one outside of the Journal 23 and – 24 Q. Which one are you referring to? 25 A. This one in the Journal of Urology.	20
1 Q. Okay. And how about – I'm also 2 going to show you an article by Welch, et al., from 3 Journal of the American Medical Association, Are 4 Increasing Five Year Survival Rates Evidence of 5 Success Against Cancer? 6 MR. WATTLEWORTH: Let's go off the 7 record for a second. 8 (Discussion off the record.) 9 MR. LEGER: And let's just clarify 10 that on the record. 11 MR. WATTLEWORTH: Sure, yeah. 12 BY MR. LEGER: 13 Q. As I appreciated, the JAMA article 14 that you just looked at by Welch is not an article 15 that you have reviewed in formulating your 16 opinions; is that correct? 17 A. Or I've seen before; that's correct. 18 Q. It was never provided to you by 19 anybody but me at this deposition? 20 A. That's correct. 21 Q. Okay. And apparently it was 22 mistakenly provided to us, suggesting that you 23 relied upon it; correct? 24 A. That's correct. 25 Q. All right. The other two, however,	19 1 Comparative Sensitivity by Marta Sanchez-Carbayo. 2 This one from Adult Urology, the Comparative 3 Evaluation of the BTA Stat Test, I think I read 4 this one, and this was provided by the tobacco 5 company. 6 Q. Okay. Now, you say you may have – 7 did you make copies, though, and send these as if 8 to be provided to us? 9 A. I didn't make – 10 Q. Okay. 11 A. – copies, no. 12 MR. LEGER: And we don't need to 13 even identify them, unless you would prefer us to. 14 MR. WATTLEWORTH: No. 15 MR. LEGER: I'm just trying to 16 get – 17 MR. WATTLEWORTH: I think, since 18 we've identified the authors – 19 MR. LEGER: Yeah. 20 MR. WATTLEWORTH: – we have an idea 21 of what we're talking about. 22 BY MR. LEGER: 23 Q. Now, in connection with the articles 24 that we just spoke about, the four articles we 25 spoke about that are not listed in here, you saw	21

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<p>1 those articles after — after your opinions were  2 given in this report?</p> <p>3 A. Possibly, yes.</p> <p>4 Q. Did they materially affect your  5 opinion in any way?</p> <p>6 A. No.</p> <p>7 Q. Change it, modify it, otherwise?</p> <p>8 A. No. It's just additional data.</p> <p>9 MR. LEGER: Chris, I think I've  10 numbered these right.</p> <p>11 MS. DESUE: Yes.</p> <p>12 BY MR. LEGER:</p> <p>13 Q. Now, other than the articles that  14 we've talked about and the articles on Cockburn  15 No. 3, there's so documents and articles, are  16 there any other materials, documents, writings,  17 databases, otherwise, that you relied on in  18 formulating opinions, other than general — the  19 general body of —</p> <p>20 A. No.</p> <p>21 Q. — of knowledge?</p> <p>22 A. Other than the general body of  23 knowledge that's available, no.</p> <p>24 Q. Did you particularly rely upon, —  25 perhaps any treatises or textbooks in</p>	<p>22</p> <p>1 A. None that I'd specifically want to  2 mention, no.</p> <p>3 Q. Okay. And you consider that  4 Campbell's Urology, that textbook, is  5 authoritative?</p> <p>6 A. I do.</p> <p>7 Q. Is it a textbook which you rely upon  8 regularly in the context of your practice?</p> <p>9 A. I do, as a reference.</p> <p>10 Q. Are there any other references that  11 you consider important in your ordinary practice?</p> <p>12 A. Other than the journals, no.</p> <p>13 Q. Which journals do you consider  14 important?</p> <p>15 A. Urology, Journal of Urology,  16 Investigative Urology, Contemporary Urology.</p> <p>17 Q. Are there any particular journals  18 that you consider important and reliable in the  19 context of oncology?</p> <p>20 A. Yes; Cancer, CA, the cancer journal  21 put out by the ACS, Oncology News.</p> <p>22 Q. Do you prescribe — I'm sorry —  23 subscribe to any of these publications?</p> <p>24 A. I do.</p> <p>25 Q. Do you subscribe to all of them,</p>
<p>1 particularly — in particular language in treatises  2 and textbooks in formulating those opinions?</p> <p>3 A. No.</p> <p>4 Q. Are there any particular —</p> <p>5 MR. WATTLEWORTH: I've got a  6 question. Are you talking about outside of what's  7 listed on his reliance list?</p> <p>8 MR. LEGER: Outside of what's listed  9 on his —</p> <p>10 MR. WATTLEWORTH: Okay.</p> <p>11 MR. LEGER: — on the reliance.</p> <p>12 MR. WATTLEWORTH: Because Campbell's  13 Urology is listed on there.</p> <p>14 MR. LEGER: Yes, mm-hmm.</p> <p>15 THE DEPONENT: Well, that's — no.</p> <p>16 Outside of that, no.</p> <p>17 BY MR. LEGER:</p> <p>18 Q. And there are a number of other  19 tests in — texts in urology and in uro-oncology, I  20 assume; correct?</p> <p>21 A. That's correct.</p> <p>22 Q. Are there any particular texts,  23 other than Campbell's Urology, that you consider  24 authoritative in the context of what we're talking  25 about in this case?</p>	<p>23</p> <p>1 basically, that you just listed?</p> <p>2 A. No. I subscribe to Urology,  3 Contemporary Urology. The others I read in --  4 either on the Internet or the library.</p> <p>5 Q. So you do not subscribe to any of  6 the cancer journals?</p> <p>7 A. No, I don't.</p> <p>8 Q. Or oncology materials; correct?</p> <p>9 A. Correct.</p> <p>10 Q. Have you been provided with copies  11 of any medical records pertaining to Gloria Scott  12 and Deania Jackson?</p> <p>13 A. No, I haven't.</p> <p>14 Q. Do you expect to be provided any  15 such records?</p> <p>16 A. No.</p> <p>17 Q. Have you asked for records?</p> <p>18 A. No.</p> <p>19 Q. Do you know who Gloria Scott and  20 Deania Jackson are?</p> <p>21 A. No, I don't.</p> <p>22 Q. Do you — this subpoena requested  23 your billing records. Have you provided a copy of  24 those billing records?</p> <p>25 A. I don't think I have, because I just</p>

<p>1 submitted a bill maybe a month ago.  2 Q. Do you remember what that bill was  3 for, in terms of how much?  4 A. About \$3,000.  5 Q. And how much are you charging in  6 this case?  7 A. I think it's on the report, \$300 for  8 a deposition, or \$350, something like that.  9 Q. Okay. If I told you were — you  10 said you were charging \$350 for consultation and  11 \$500 for a deposition, would that surprise you?  12 A. No, but it would sound better.  13 Q. Doctor, in the Engles case, you  14 testified that you were charging \$250 an hour --  15 A. Uh-huh.  16 Q. — is that correct?  17 A. Yes. Inflation has been going up.  18 Q. So do you consider that it's a  19 result of inflation that you've increased your fees  20 or are you more expert now?  21 A. I've increased my fees not because  22 I'm more expert, just because of the hassle factor,  23 maybe.  24 Q. Explain the hassle factor, sir.  25 A. Just it's not medicine. It's not</p>	<p>26 something as was named here, the NMP-22, as the  2 specific test of choice for an evaluation that has  3 already been established as a — the normative way  4 of approaching someone with blood in the urine.  5 Q. Okay. Explain that. You object to  6 the monitoring program?  7 A. Oh, no. No, not at all do I  8 disagree with the monitoring program. I think we  9 have to have a monitoring program. I disagree with  10 the form.  11 Q. Okay. Let's talk about that. You  12 agree, it is your opinion that a monitoring program  13 to attempt to detect bladder cancer at an early  14 stage is good, sound medicine and science --  15 A. Absolutely.  16 Q. -- correct? Where we — where you  17 disagree is the particular methodology of the  18 program proposed --  19 A. That's correct.  20 Q. — by the scholars and doctors and  21 professors in the state of Louisiana?  22 A. That's correct.  23 Q. Okay. Can you explain to me  24 particularly what it is you disagree with?  25 A. The form, as I see it, implies that</p>
<p>1 what I'm used to. It's not what I like. It's not  2 pleasant.  3 Q. Why did you agree to do it?  4 A. Partly because I think that, as I  5 was in the Engle case, I feel strongly about one's  6 need to accept responsibility for one's actions  7 and — instead of blaming outside forces, like  8 addiction and things like that, for things that we  9 do.  10 Q. What does that have to do with your  11 testimony as an expert urologist?  12 A. Well, in this case, as was presented  13 for screening for bladder cancer, I disagreed with  14 the proposal as it was and I didn't think that that  15 was good medicine, and that's the main reason.  16 Q. Do you have an idea of better  17 medicine?  18 A. I think so.  19 Q. Okay. What is that?  20 A. I think that it involves a screening  21 method that is based on a routine examination that  22 we all do, and that is a urinalysis, and that it  23 should be followed by the same normative practices  24 that we do for anyone with an abnormal urinalysis;  25 and I don't think that we specifically have to name</p>	<p>27 29  1 individuals who — as I understand it, who have  2 been exposed to tobacco smoke by smoking themselves  3 are therefore susceptible to developing bladder  4 cancer, and therefore, as I understand it, all of  5 those individuals deemed potentially vulnerable  6 ought to be evaluated by the methods that were  7 described; and I take issue with only one of those  8 tests.  9 Q. Which test?  10 A. The NMP-22.  11 Q. Okay. So do I understand, then —  12 and I'm really just trying to establish our points  13 of agreement so we can talk about what we disagree  14 on. Do I understand that you agree that persons  15 who are exposed to tobacco smoke by smoking should  16 be monitored for bladder cancer?  17 A. As anyone over the age of 50 should  18 be, yes.  19 Q. Well, do you — let me see if I can  20 make sure we understand each other. Is it your  21 testimony that everyone, whether they smoke or not,  22 should be monitored for bladder cancer?  23 A. It depends on what you mean by  24 "monitored." We monitor individuals when they  25 present to us for a physical examination by looking</p>

<p>1 at their urine. Is that cancer detection or is  2 that monitoring?</p> <p>3 Q. Okay. Let's factor out a physical  4 examination because -- let's talk about the  5 physical examination aspect. There is no organized  6 program that allows for funding of regular physical  7 examinations; is that correct -- in America?</p> <p>8 A. No, that's correct.</p> <p>9 Q. No, there is no program?</p> <p>10 A. That's correct; there is no program.</p> <p>11 Q. Is there a program for monitoring  12 for individuals in the population with no  13 particular risk factors in the state of Florida?</p> <p>14 A. When you say "a program," that means  15 sponsored by --</p> <p>16 Q. Someone paying for it.</p> <p>17 A. No.</p> <p>18 Q. Are you aware of such a program in  19 the state of Louisiana?</p> <p>20 A. No.</p> <p>21 Q. Is there a recommendation by any  22 medical associations or health care organizations  23 for such program?</p> <p>24 A. I don't know of one.</p> <p>25 Q. Okay. I mean, in Florida or</p>	<p>30</p> <p>1 MR. WATTLEWORTH: Object to the  2 form.</p> <p>3 A. We advocate it.</p> <p>4 BY MR. LEGER:</p> <p>5 Q. Who is "we"?</p> <p>6 A. The medical community advocates that  7 everyone over the age of 50 should be seen by a  8 doctor on an annual basis.</p> <p>9 Q. Okay. Where do you advocate it and  10 how do you advocate it?</p> <p>11 A. Daily to my patients.</p> <p>12 Q. To your --</p> <p>13 A. It's not done through -- I don't  14 know of the American Medical Association having a  15 policy like this or that has been advertised as  16 such, but it is certainly practiced on a daily  17 basis, I think, by most physicians, who recommend  18 that over a certain age, individuals should be  19 examined at least once a year.</p> <p>20 Q. What we know is, though, that it is  21 a clear, minuscule minority of people in America  22 that do go in for annual physicals; isn't that  23 true?</p> <p>24 MR. WATTLEWORTH: Object to form.</p> <p>25 A. We don't have a national health</p>	<p>32</p>
<p>1 Louisianian in the United States of America,  2 you're not aware of any; correct?</p> <p>3 A. No, I'm not.</p> <p>4 Q. Or in any other country in the  5 world; is that correct? -- You're not aware.  6 There may be, but you're not aware; correct?</p> <p>7 A. There may be, but I'm not aware.</p> <p>8 Q. Okay. Now, so generally what you  9 suggest is that, however, if a person is seen in a  10 doctor's office for an examination on an ordinary  11 basis, one of the things that they should be tested  12 for is urinalysis -- or a urinalysis should be  13 done?</p> <p>14 A. That depends on how general and  15 specific you want to make the word "examination."  16 If they're coming in for an annual examination,  17 yes, I think that should be. If they're coming up  18 for a follow-up on their heart medicine, no.</p> <p>19 Q. The fact of the matter is, though,  20 Doctor -- and I don't really mean to quibble with  21 you, though, but -- in the context of the health  22 care system in the United States of America, it is  23 not ordinary for Americans to simply come in  24 annually for a, quote, physical examination; isn't  25 that true?</p>	<p>31</p> <p>1 system.</p> <p>2 BY MR. LEGER:</p> <p>3 Q. Exactly. But, I mean, the point is,  4 Doctor, that -- I mean, you would agree, though,  5 that a very small minority of people in America do  6 go in for annual physicals; isn't that right?</p> <p>7 MR. WATTLEWORTH: Object to the  8 form.</p> <p>9 A. I don't know -- I don't know that I  10 would say a small minority.</p> <p>11 BY MR. LEGER:</p> <p>12 Q. Would you say a medium minority?</p> <p>13 MR. WATTLEWORTH: Object to the  14 form. What do you mean by "medium minority"?</p> <p>15 MR. LEGER: I don't know. That's  16 what I'm trying to find out, what he knows.</p> <p>17 BY MR. LEGER:</p> <p>18 Q. Is -- the next one is a large  19 minority? I --</p> <p>20 A. It depends on population groups,  21 income strata, all of those. Most people don't go  22 to a doctor unless they have a complaint.</p> <p>23 Q. Exactly.</p> <p>24 A. Yes.</p> <p>25 Q. And, Doctor, there are, however,</p>	<p>33</p>

<p>1 some companies that will pay for annual physicals  2 by employees; correct?  3 A. That's correct.  4 Q. There are some programs that allow  5 for payment of annual physicals; correct?  6 A. That's correct.  7 Q. The — if an individual walks in off  8 the street to a doctor's office, under the current  9 American health care system, and says, I want a  10 physical examination, will most insurance companies  11 pay for the physical examination?  12 A. Yes.  13 Q. Even with no symptoms, no  14 symptomology?  15 A. That's correct.  16 Q. Okay. When a person comes into a  17 family practitioner's office for a physical  18 examination, what does the doctor do, ordinarily?  19 A. An asymptomatic individual comes  20 into the doctor and says, I'd like to have a  21 physical exam?  22 Q. Mm-hmm.  23 A. I think he gets a physical  24 examination; he gets a urinalysis; most likely,  25 he'll get some blood work — a CBC, a basic</p>	<p>34. 1 whether they're paying for it themselves or whether  2 their insurance companies are paying for it?  3 A. I do know: I know that most of them  4 do pay a co-payment but that the insurance company  5 pays for the procedure.  6 Q. Okay. Now, do you know, in the case  7 of those patients that come in for annual  8 physicals, whether they're part of a particular  9 employer group program or otherwise?  10 A. No. I think that most of them do  11 not have a — the program you describe.  12 Q. Okay. Now, let's get back to this  13 particular program. You believe that, in  14 connection with a physical examination, it is  15 entirely appropriate and proper and medically sound  16 to perform a urinalysis even in a person who has no  17 particular known risk to bladder cancer; correct?  18 A. Absolutely.  19 Q. Okay. And what are you looking for  20 in a urinalysis?  21 A. What do you look for in a  22 urinalysis?  23 Q. Yes, sir.  24 A. Glucose, ketones, bilirubin, blood,  25 leukocytes, nitrite, protein.</p>
<p>1 metabolic profile — and then, depending, he may  2 get an EKG; and depending on his age or her age,  3 they may have a colonoscopy.  4 Q. So does he get a cystoscopy (sic)?  5 A. Cystoscopy?  6 Q. Cystoscopy.  7 A. No, unless indicated by blood in the  8 urine.  9 Q. And it's your testimony that  10 insurance companies will pay for all of those tests  11 without evidence of symptom?  12 MR. WATTLEWORTH: Object to the  13 form.  14 A. I honestly don't know. My  15 impression is that they do, simply because I see a  16 fair number of patients who do come in annually  17 with no complaints, just for a checkup, and I  18 haven't heard any complaints from them that the  19 insurance company did not pay for it or would not  20 pay for it or that they were afraid that the  21 insurance company would not pay for it.  22 BY MR. LEGER:  23 Q. Okay. So the fact of the matter is  24 that you don't know whether, in the case of your  25 patients who come in for an annual physical —</p>	<p>35. 1 Q. And what are you looking for in the  2 context of attempting to determine bladder cancer?  3 A. Blood or protein.  4 Q. Now, with respect to further  5 analysis — and you're talking about in the context  6 of what you think is normal, a group with no  7 risk — now assume you do a urinalysis and you find  8 blood work which is suggestive of possible bladder  9 cancer; correct?  10 A. Not blood work; you find blood in  11 the urine.  12 Q. You find hematuria.  13 A. Correct.  14 Q. You find blood in the urine. And  15 then blood in the urine suggests what to you?  16 A. Suggests an abnormality that needs  17 to be evaluated.  18 Q. Okay.  19 A. It's a red flag.  20 Q. So now you have taken a population  21 of people who have no particular high risk for any  22 particular disease — and we're talking  23 theoretically — and now, however, once you find  24 hematuria, or blood in the urine, they are at high  25 risk for something —</p>

<p>1 A. That's correct.</p> <p>2 Q. -- correct? And you would suggest</p> <p>3 that they were -- and I'm not -- I'm leading you,</p> <p>4 really, to try to get to the point. You would</p> <p>5 agree, though, then, that they are high risk for a</p> <p>6 number of abnormalities, including bladder</p> <p>7 cancer --</p> <p>8 A. That's correct.</p> <p>9 Q. -- correct? And what are those</p> <p>10 potential problems that hematuria is suggestive of?</p> <p>11 A. Across the board, male and female,</p> <p>12 it would be stones in the collecting system, some</p> <p>13 congenital abnormality, infection, and then bladder</p> <p>14 cancer, and then for men, in particular, benign</p> <p>15 prostate hypertrophy.</p> <p>16 Q. What is benign prostatic</p> <p>17 hypertrophy?</p> <p>18 A. It's something that you and I have</p> <p>19 and will get worse from as time goes on because the</p> <p>20 prostate grows in response to trophic stimulation</p> <p>21 from testosterone, the male hormone.</p> <p>22 Q. Okay. So at that point before you</p> <p>23 do the urinalysis, and in the context of bladder</p> <p>24 cancer, the general population is certainly,</p> <p>25 obviously, not at any particular high risk for</p>	<p>38</p> <p>1 and the cytokines, etc.</p> <p>2 Q. The things mentioned in your report,</p> <p>3 the --</p> <p>4 A. That's correct.</p> <p>5 Q. -- FDP, the vascular endothelial</p> <p>6 growth factor; you're looking for molecular</p> <p>7 prognostic markers in P 53 gene, etc.; correct?</p> <p>8 A. That's correct.</p> <p>9 Q. Ordinarily, would you run all of</p> <p>10 those tests?</p> <p>11 A. No, no, not at all. Most of those</p> <p>12 are investigate -- investigative -- are in the</p> <p>13 process of being investigated. They are used in</p> <p>14 major teaching institutions, really, at this</p> <p>15 point -- not -- when I say "used," they're being</p> <p>16 evaluated. No one really is using them in a</p> <p>17 clinical basis because their reliability is</p> <p>18 certainly in question, and that's what this is all</p> <p>19 about.</p> <p>20 Q. Okay. That's where we're trying to</p> <p>21 get to. Your step, after seeing hematuria, would</p> <p>22 be, rather than running -- in a typical clinical</p> <p>23 setting -- would be, rather than running an NMP-22</p> <p>24 or a BTA Stat or an FDP or Telomerase assay or</p> <p>25 otherwise, would be cystoscopy; right?</p> <p>40</p>
<p>1 bladder cancer; correct?</p> <p>2 A. That's correct.</p> <p>3 Q. Alright. Now, once you have</p> <p>4 determined that there's hematuria, the general --</p> <p>5 that population -- or that person who has hematuria</p> <p>6 is now determined to be at high risk for stones,</p> <p>7 congenital abnormalities, infection, bladder</p> <p>8 cancer, benign prostatic --</p> <p>9 A. Hypertrophy.</p> <p>10 Q. -- hypertrophy?</p> <p>11 A. Not high risk, but high suspicion.</p> <p>12 Q. Okay. And the next step is what?</p> <p>13 A. We follow an algorithm to evaluate</p> <p>14 the entire urinary tract. We do an IVP, an</p> <p>15 intravenous pyelogram, to delineate the upper</p> <p>16 collecting system and the ureter; and then we look</p> <p>17 into the bladder cystoscopically with a cystoscope,</p> <p>18 and then that gives direct visualization of the</p> <p>19 bladder, the prostate, and the urethra. We obtain</p> <p>20 a urine specimen for cytologic evaluation, and we</p> <p>21 send off a urine culture.</p> <p>22 Now, we're exploring the use of</p> <p>23 various tumor markers that have been identified</p> <p>24 through molecular biological techniques, and among</p> <p>25 which are the NMP-22 and the BTA and the Telomerase</p>	<p>39</p> <p>1 A. Cystoscope, absolutely.</p> <p>2 Q. And you would also have cytology</p> <p>3 performed on the --</p> <p>4 A. On every one of them.</p> <p>5 Q. -- urine sample?</p> <p>6 A. And I want to add, I would also --</p> <p>7 if I had them available to me, I would use these</p> <p>8 other tests, as I am presently using the BTA.</p> <p>9 Okay? The problem is the expense of these tests</p> <p>10 and whether or not the insurance company will pay</p> <p>11 for them.</p> <p>12 Q. All right. So you say you would use</p> <p>13 them because you believe -- and you've looked at</p> <p>14 the articles -- you believe that they have reached</p> <p>15 sufficient scientific acceptability?</p> <p>16 MR. WATTLEWORTH: Object to the</p> <p>17 form.</p> <p>18 BY MR. LEGER:</p> <p>19 Q. Correct?</p> <p>20 A. I think that they have reached --</p> <p>21 certainly, they've reached -- as far as the</p> <p>22 NMP-22 -- have reached regulatory acceptability by</p> <p>23 the FDA, so they have approved it for that.</p> <p>24 Again, the problem comes down to</p> <p>25 utility and cost, and it is used adjunctively with</p> <p>41</p>

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1 the other established methods. 2 Q. Mm-hmm. 3 A. So the BTA and the NMP-22 are used 4 but, again, as an adjunct to these others. 5 Q. And I guess that's my question. Do 6 you have any objection to the use of BTA Stat as a 7 diagnostic tool? 8 A. I do. 9 Q. Okay. What is that? 10 A. A high failure rate, both in terms 11 of false positives in patients with hematuria and 12 false negatives in those patients who have fairly 13 well differentiated low grade tumors. 14 Q. Do you think BTA Stat, in your mind, 15 is insufficiently specific in low grade tumor? 16 A. It's sensitive for low grade tumor. 17 Q. It is sensitive? 18 A. In - not sufficiently sensitive for 19 low grade tumors. 20 Q. But is - has been - but is 21 sufficiently sensitive in invasive tumors - 22 A. Yes. 23 Q. - correct? Okay. What about 24 NMP-22 regarding low grade tumor? 25 A. A little better than BTA, but it's	42 1 Q. What is the price? 2 A. I don't know what, specifically, the 3 price is for the NMP-22. I know for urine cytology 4 ranges anywhere from about \$120 to up to \$300, 5 depending on what you get with your study and 6 who - what company does it. 7 Q. Okay. How much does a - strike 8 that. 9 What would be a reasonable price? 10 What would be a price that would make it worthwhile 11 to you to use it? 12 A. Something that the government and 13 the insurance companies would pay for. 14 Q. Okay. Under \$100 for cytology? 15 A. Well, you know, it's nice to throw 16 out a figure, but it's a matter of preparation. 17 The cytologist has to see it, and then it has to be 18 reviewed by a cytopathologist, so there are a lot 19 of steps in there, and that's what adds the cost 20 into it. 21 Q. Now, a cytologist is a technician, 22 basically; correct? 23 A. Yes. 24 Q. And a - 25 A. A highly skilled technician.
43 1 sometimes not as good as regular urine cytology. 2 Q. Okay. And what about in invasive 3 tumor? 4 A. Invasive tumor, they - it tends to 5 track well, with a higher specificity and 6 sensitivity, and in that case, better than urine 7 cytology. 8 Q. Now, you note that the plan 9 recommended by the doctors in Louisiana calls for 10 both NMP-22 and cytology; correct? 11 A. That's correct. 12 Q. Do you have an opinion as to the 13 usefulness of those two items together? 14 A. Oh, I think that they're - they are 15 additive and synergistic. 16 Q. So basically, would you agree that 17 they effectively complement each other? 18 A. They do. 19 Q. They fill the weakness of each 20 other; correct? 21 MR. WATTLEWORTH: Object to the 22 form. 23 BY MR. LEGER: 24 Q. Is that your opinion? 25 A. Yeah, for a price.	45 1 Q. And a cytopathologist, is that a 2 doctor - 3 A. Yes. 4 Q. - medical doctor? 5 Okay. Doctor, I want you to take 6 the cost factor out now. 7 A. Mm-hmm. 8 Q. Assume, hypothetically, that cost is 9 not a factor. Would you agree that the two of 10 these tests, used together, are effective and would 11 be recommended for attempting to monitor for 12 bladder cancer? 13 A. In what individuals? 14 Q. In an individual in whom hematuria 15 is found. 16 A. Oh, yes. Yes, I think there's a 17 clear role for both of those there, or some tests 18 as good or better than the NMP, yes. The reason we 19 have the NMP is because of the failings of the 20 cytology, so if we find something that's better 21 than, across the board, we're going to use it. 22 Q. Are the other tests that you talk 23 about - BTA Stat, FDP, Telomerase assay, and 24 others - are those complementary with cytology? 25 Are any of those any better than NMP-22?

1	A. Well, you see, as you might gather 2 from the gist of my article, they're all out there 3 and being evaluated at the present time and being 4 compared against each other in the same 5 populations, and we find that there's such a 6 variance in their sensitivity and their specificity 7 reported by different groups around the country and 8 outside of the country that it's hard for the 9 clinician to say at any one point in time that this 10 one is better than this one.  11 And so at the present time, since 12 basically the only -- the NMP-22 and the BTA are 13 available to the average clinician, the others are 14 basically investigative things.  15 Q. And what you're saying is, those two 16 have been avail -- they're available to the average 17 clinician in terms of they've been approved for use 18 by the FDA; is that correct?  19 A. That's correct.  20 MR. WATTLEWORTH: Object to the 21 form.  22 BY MR. LEGER: 23 Q. The others have -- I'm sorry. Have 24 BTAs been approved by use in a clinical doctor 25 by the FDA?	46	1 form. 2 A. As far as I know, it is approved for 3 use, yes, by the FDA. 4 MR. LEGER: What was objectionable 5 about the form? 6 MR. WATTLEWORTH: What type of use? 7 BY MR. LEGER: 8 Q. Okay. Is the -- let's see if we can 9 straighten this out. Is the NMPA test approved as 10 a diagnostic tool for urologists to detect bladder 11 cancer? 12 A. Yes, it is. 13 Q. By the FDA; correct? 14 A. (Deponent nods head.) 15 Q. Okay. And it is available to you, 16 as a urologist, for use in your office in 17 attempting to detect bladder cancer; correct? 18 A. That's correct. 19 Q. Okay. Now, in the context of what 20 we talked about, and you provided us -- actually, 21 you provided yourself with, or someone provided to 22 you -- a number of articles regarding these various 23 tests, and those articles apparently investigated 24 the efficacy and the usefulness and the accuracy of 25 the various tests we've talked about; correct?	48
1	A. It is -- I don't know if it is -- 2 actually, I don't know if it is FDA approved. I 3 know it is available, and I have it in my office -- 4 Q. Okay. 5 A. -- so I assume that -- 6 Q. And "available" means there's 7 nothing wrong with you using it? 8 A. That's correct.  9 MR. WATTLEWORTH: Object to the 10 form. 11 BY MR. LEGER: 12 Q. Does it have to be FDA approved for you to use it? 14 A. I don't think so. 15 Q. I mean, it doesn't hurt anybody -- 16 A. No. 17 Q. -- if you use it; right? It's a 18 laboratory test? 19 A. But FDA approval is what the 20 insurance companies look for, for their willingness 21 to pay for it. 22 Q. Okay. Now, is the NMP-22 use 23 approved by the FDA? 24 A. It is, yes.  25 MR. WATTLEWORTH: Object to the	47	1 A. Correct. 2 Q. And you just testified a few minutes 3 ago that there are mixed results in terms of the 4 efficacy of those tests relative to each other -- 5 A. Correct. 6 Q. -- correct? Generally, though, each 7 one of those that you referred to in your report 8 has been found to be relatively effective; correct? 9 MR. WATTLEWORTH: Object to the 10 form. 11 A. Of some value. 12 BY MR. LEGER: 13 Q. Of some value, right. And -- but 14 the question in the literature that you spoke of 15 is, what is the relative effectiveness to each 16 other; correct? 17 A. That's correct. 18 Q. Okay. Now, in the context of 19 monitoring for bladder cancer in a person who has 20 been found to have hematuria or -- strike that. 21 In the context of monitoring for 22 bladder cancer in a population of persons who have 23 been found to have hematuria, is a cystoscope a 24 recommendable tool? 25 A. Absolutely, to the point of being	49

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1 indispensable.  
2 Q. And why is that?  
3 A. Well, what's better than direct  
4 visualization?  
5 Q. Explain a cystoscope, if you would.  
6 A. Well, cystoscopy presently is  
7 performed most often with a flexible cystoscope. A  
8 cystoscope has the diameter of about 18 french,  
9 which is a little smaller than this pen.  
10 Q. Okay.  
11 A. It's introduced into the urethra  
12 after it's anesthetized with Xylocaine, and because  
13 it is flexible, it's far more comfortable than that  
14 which was used up till maybe even five years ago,  
15 which was a rigid rod that you accommodated to  
16 rather than it to you and, as such, it's now done  
17 as an outpatient --  
18 Q. I'm sorry, Doctor.  
19 A. There's nothing nice that happens in  
20 a doctor's office.  
21 Q. Right.  
22 A. It's all uncomfortable and --  
23 Q. Particularly this.  
24 A. Well, from my patients every day,  
25 there's nothing pleasant that happens in a doctor's

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1 a -- I mean, you're simply extending your normal  
2 view; correct?  
3 A. Correct.  
4 Q. Can you magnify what you're looking  
5 at?  
6 A. It's magnified ten times.  
7 Q. Okay. And you visually examine the  
8 wall of the bladder --  
9 A. That's correct.  
10 Q. -- when you do that? There's a  
11 little light, I assume, that you can --  
12 A. Very powerful light.  
13 Q. Very powerful light --  
14 A. Fiber optic.  
15 Q. -- so that you can see it. And  
16 there are very observable physical characteristics  
17 of malignant tumor?  
18 A. That's correct.  
19 Q. Okay. Would you agree with the  
20 general proposition that the earlier you can detect  
21 the presence of malignant tumor, the better the  
22 prognosis?  
23 A. That's a truism; that's correct.  
24 Q. Okay. And that's a general truism  
25 in the context of oncology; correct?

52

1 Q. Okay.  
2 Q. That's true.  
3 A. Okay? Now, I go there for that,  
4 So with that acknowledgment, you accede to it. The  
5 telescope is then advanced beyond the prostate into  
6 the bladder in the male, just simply into the  
7 bladder through a short urethra in the female, and  
8 you're able to investigate the entire circumference  
9 of the bladder, mainly because your cystoscope is  
10 very flexible at the tip. Rather than being rigid  
11 and having to use oblique lenses and things like  
12 that, you can now visualize every bit of it.  
13 So not only do you know that the  
14 patient has a tumor, but you know the location of  
15 the tumor and the characteristics of the tumor, its  
16 proximity to the urethral orifices when you're  
17 considering resecting it, etc., etc., etc.  
18 Q. Okay. So in other words, when you  
19 use a cystoscope, I mean, you're looking in a  
20 camera that's looking inside the bladder, correct?  
21 A. You can. You can. My -- I have an  
22 attachment -- a camera that attaches to it so the  
23 patient can see on the video what we're looking at  
24 or you can look directly into the lens yourself.  
25 Q. I'm sorry. It's almost like using

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1 A. That's correct.  
2 Q. And not just bladder cancer;  
3 correct?  
4 A. You can say that about all medicine.  
5 Q. Okay. So would you also agree with  
6 the general proposition that in the context of  
7 malignant tumors, the earlier you find -- you  
8 observe the tumor, generally, the smaller it is?  
9 MR. WATILEWORTH: Are you talking  
10 about bladder tumors?  
11 MR. LEGER: I'm talking about tumors  
12 in general -- cancer tumors in general.  
13 BY MR. LEGER:  
14 Q. I mean, the cancer doesn't get  
15 smaller as it gets worse; correct?  
16 A. Okay. Cancer is not cancer is not  
17 cancer.  
18 Q. Okay.  
19 A. Okay? There are grades of tumor.  
20 There are different types of tumors.  
21 Q. Right.  
22 A. And there are certain tumors -- 80  
23 percent of bladder tumors are superficial and don't  
24 go on to anything more than that, so in that  
25 context, you may look at a tumor now and come back

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<p>54</p> <p>1 a year later and it'll be the same size.      2 Q. Okay.      3 A. That's its natural history. It's      4 not going to grow any more than that. The      5 potential for invasion is there, and since we have      6 no ability to detect whether or not that is going      7 to be invasive, yes, we do attack it at that time      8 and remove it.      9 Q. So when you say "superficial"      10 and -- I'm sorry -- 80 percent of the bladder      11 tumors are what you call superficial tumors --      12 A. That's correct.      13 Q. -- correct? What that means is that      14 they are found only in the -- I guess, the      15 outermost or innermost tissue of the bladder?      16 A. That's correct. They are in the      17 most superficial layer of the bladder, that being      18 the epithelium, limited by the basement membrane      19 below, which is the submucosa.      20 Q. If you don't do anything with it,      21 and assume it doesn't evade --      22 A. Invade.      23 Q. -- invade other layers of tissue,      24 will it spread in the epithelium?      25 A. For the vast majority of these</p>	<p>55</p> <p>1 Was that a bad question?      2 A. Yeah.      3 Q. Okay.      4 A. Can you rephrase that?      5 Q. I'm not sure I can, Doctor. In      6 other words, I guess, in your mind as a doctor, as      7 a treating doctor -- treating physician in the      8 context of bladder cancer, you categorize the      9 tumors --      10 A. Yes.      11 Q. -- and one of the reasons you      12 categorize is because you know, clinically, that      13 some tests are better at finding that type of      14 tumor?      15 MR. WATTLEWORTH: Object to the      16 form.      17 BY MR. LEGER:      18 Q. Correct?      19 A. No.      20 Q. Okay.      21 A. No. When those tests detect a      22 tumor, they don't tell us what grade the tumor is.      23 They just detect the presence of the tumor.      24 Q. Okay. And by "grade," you mean      25 what, Doctor?</p>
<p>56</p> <p>1 Q. Okay. So the risk of the      2 superficial tumor, though, is that it will spread      3 to other layers; correct?      4 A. The risk is the potential for      5 invasion.      6 Q. Okay. Now, invasion -- now, is      7 there also a risk of metastasis?      8 A. Not from a superficial tumor.      9 Q. Okay. Now, once the superficial      10 tumor invades other tissue, does it then have a      11 potential for metastasis?      12 A. That's correct.      13 Q. Okay. And at that point, then it's      14 no longer a superficial tumor?      15 A. That's correct, by definition.      16 Q. Now, there are also other bladder      17 tumors that, by their nature, are not superficial      18 but rather are invasive?      19 A. That's correct.      20 Q. And that -- and hence the      21 distinction that you made earlier between the      22 superficial tumor detection by one test over the      23 other and the invasive tumor detection potential of      24 other procedures; correct?      25</p>	<p>57</p> <p>1 A. What is -- okay. Grade is a      2 pathologic designation based on certain cytologic      3 characteristics; that is, these are characteristics      4 within the cytoplasm of the cell, or within the      5 nucleus of the cell, that are -- have been      6 characterized as having degrees of      7 dedifferentiation; that is, they don't look like      8 the normal parent tissue.      9 And the more abnormal they look, the      10 higher the grade they are, and we correlate      11 that -- we hope this is accurate -- with what      12 their potential biological activity might be, and      13 so that a higher grade tumor would tend to have a      14 more malignant behavior in the future than a lower      15 grade tumor.      16 Q. Theoretically --      17 A. And in general, that's true.      18 Q. I'm sorry. Generally, you would      19 rather catch, or find and diagnose, the malignant      20 tumor at a lower number grade; correct?      21 A. That's correct.      22 Q. If you have your preference --      23 A. Oh --      24 Q. -- as a diagnostician?      25 A. That's correct.</p>

<p>1 Q. You would rather find it at T-1 -  2 A. That's correct.  3 Q. - than find it at T-4/5; correct?  4 A. That's correct.  5 Q. And -  6 MR. WATTLEWORTH: Walter, are we  7 getting to a point where we might take a break?  8 MR. LEGER: We'll take a break,  9 yeah.  10 (A brief recess is taken.)  11 BY MR. LEGER:  12 Q. Doctor, we're going to go back to  13 this Exhibit A of Cockburn Exhibit No. 1. And we  14 had talked about - a while back about your billing  15 records, and I called for production of those, and  16 I realize you don't have them with you. But in  17 that regard, when were you first retained in this  18 case?  19 A. I think in May of this year -  20 April.  21 Q. And how were you first contacted?  22 A. My contact person with the firm with  23 whom I had dealt with through the Engle case  24 advised me of this pending litigation.  25 Q. And who is that?.</p>	<p>58</p> <p>1 Monitoring. Have you seen that document? It might  2 have been attached to a report of Dr. David Burns.  3 A. I think so, yes. It looks familiar.  4 Q. And there is specific reference -  5 A. Yes.  6 Q. - to the medical monitoring  7 program. You agree, Doctor, that there's - I'm  8 sorry - medical monitoring regarding bladder  9 cancer is referred to in that document, as well  10 as -  11 A. Yes.  12 Q. - several other diseases?  13 A. Yes, I did see that.  14 Q. Now, you also saw that there's a  15 little bit more lengthy analysis of the bladder  16 cancer issue, particularly in Dr. Sartor's report;  17 correct?  18 A. Correct.  19 Q. Doctor, do you agree that the  20 American Cancer Society states that bladder cancer  21 screening is not recommended for people without  22 symptoms who do not have strong risk factors for  23 this disease?  24 A. Yes.  25 MR. WATTLEWORTH: Object to the</p>
<p>1 A. Ursula Henninger.  2 Q. And what firm is she with?  3 A. This one (indicating).  4 Q. The firm in North Carolina?  5 A. That's correct.  6 Q. She called you on the phone?  7 A. Correct.  8 Q. And what did she tell you about this  9 case?  10 A. Just the nuts and bolts of it; that  11 it was involved with the monitoring of individuals  12 who had been exposed to tobacco.  13 Q. And what did she ask you to do?  14 A. Review the data that she would send  15 me, which basically were the reports by, I think,  16 Dr. Wiener and Dr. Sartor.  17 Q. Okay. Did she eventually also send  18 you a copy of what's - what is called the  19 monitoring program, a document separate from the  20 direct reports of Dr. Wiener and Sartor?  21 A. And who is the author of that one?  22 Q. Well, it is a group of doctors and  23 scholars and medical school people, and I'm going  24 to just show you - it's called The Clinical Value  25 of Early Detection and Diagnosis and of Medical</p>	<p>59</p> <p>1 form.  2 BY MR. LEGER:  3 Q. You do agree?  4 A. Yes.  5 Q. And do you also agree the American  6 Cancer Society goes on to state risk factors that  7 would justify a screening include proven exposure  8 to cancer-causing chemicals, earlier bladder  9 cancers, or certain birth defects of the bladder?  10 MR. WATTLEWORTH: I'm going to.  11 object. Just where are you - what are you  12 referring to right now? Are you reading out of a  13 particular report?  14 MR. LEGER: I'm reading out of  15 Dr. Sartor's report as quoting the American Cancer  16 Society.  17 MS. WIMBERLY: And, Walter, are you  18 asking if he agrees -  19 MR. LEGER: If he agrees that's what  20 it says.  21 MS. WIMBERLY: - that's what it  22 says?  23 MR. LEGER: That's right.  24 MR. WATTLEWORTH: That's what his  25 report says?</p>

<p>1                   MR. LEGER: That's what the report 2 says. 3                   MR. WATTLEWORTH: Right. That's 4 your question, if he -- 5                   MR. LEGER: And I'm asking -- 6 no -- if that's what the -- if he agrees that's 7 what the American Cancer Society says. 8                   THE DEPONENT: You know, the 9 American Cancer Society says so; but in their 10 cancer magazine, they say -- the CA, the cancer 11 magazine of the American Cancer Society -- they say 12 nothing about bladder cancer monitoring. 13 BY MR. LEGER: 14                   Q. Okay. And where do they not say -- 15 I'm sorry -- tell me, again, the name of -- 16 it. The CA cancer journal for cancer 17 detection really has no data on there about bladder 18 cancer. 19                   Q. Okay. Are you talking about on the 20 Internet or are you talking about the volumes or 21 the magazine that you get -- 22                   A. The magazine itself. 23                   Q. -- periodically? 24                   A. Yes. 25                   Q. Okay. Have you researched it to</p>	<p>62</p> <p>1                   A. Well, I agree that people with risk 2 factors and symptoms should be evaluated for 3 bladder cancer, yes. 4                   Q. All right. How about people with no 5 symptoms but strong risk factors? Do you think 6 they should be monitored? 7                   A. And when you say "monitored," you 8 mean -- 9                   Q. I mean, well, screened. 10                  A. And that screening would be? 11                  Q. In any way. I'm talking about any 12 type of screening. 13                  MR. WATTLEWORTH: For any disease? 14                  MR. LEGER: No, for bladder cancer. 15                  A. Yes, I think, and that screening is 16 the urinalysis. 17 BY MR. LEGER: 18                  Q. Okay. And you would agree that -- 19 or would you agree that risk factors that would 20 justify a screening would include proven exposure 21 to cancer-causing chemicals? 22                  A. And when you say that "screening," 23 are you talking about the average individual who 24 walks into the doctor's office who says, Yes, I 25 work in an aniline dye factory, or, I work for the</p>	<p>64</p>
<p>1                   determine if there's -- 2                  A. Only to look through the ACS Web 3 site. 4                  Q. And you particularly looked for a 5 specific reference to bladder cancer -- 6                  A. Yes. 7                  Q. -- correct? Do you recall what 8 search criteria you used or search parameters you 9 used? 10                  MR. WATTLEWORTH: In looking through 11 the American Cancer Society Web site? 12                  MR. LEGER: Web site, yeah. 13                  A. No, just cancer detection. 14 BY MR. LEGER: 15                  Q. Would you disagree with the 16 suggestion that bladder cancer should not be 17 screened in people with symptoms who do not have 18 strong risk factors? 19                  MR. WATTLEWORTH: Object to the 20 form? 21                  A. Do I disagree that people should not 22 be -- 23 BY MR. LEGER: 24                  Q. Do you agree or disagree with that 25 statement?</p>	<p>63</p> <p>1                   petroleum industry in distillation, or -- those 2 individuals or those individuals walking into a 3 general physician's office should be screened per 4 se? 5                  Q. Let's talk about those, then -- 6                  A. Yeah, I figure -- 7                  Q. -- if that's what you would like to 8 do. 9                  A. -- they should definitely have a 10 urinalysis. 11                  Q. Okay. Why should people who work in 12 the aniline dye industry be screened? 13                  A. It just has a higher association of 14 bladder cancer in those individuals who are exposed 15 to aniline dyes. 16                  Q. What is the level of association, if 17 you know? 18                  A. That there's a risk associated, 19 higher than normal. 20                  Q. All right. What is the known 21 association in the context of persons who work in 22 the petroleum industry? 23                  A. Again, only a higher association. 24                  Q. Okay. And you would advocate 25 screening in those cases, also; is that correct?</p>	<p>65</p>

<p>1 A. Yes.</p> <p>2 Q. Okay. Would you also advocate</p> <p>3 screening for bladder cancer in the case of persons</p> <p>4 who have long-term exposure to cigarette smoke?</p> <p>5 MR. WATTLEWORTH: Object to the</p> <p>6 form.</p> <p>7 A. I want to just make a qualification</p> <p>8 here. When someone walks into a doctor's office,</p> <p>9 and they're coming asymptotically for a general</p> <p>10 medical evaluation, they're going to get a screen,</p> <p>11 if that's the word you want to use.</p> <p>12 BY MR. LEGER:</p> <p>13 Q. Right.</p> <p>14 A. They're going to be screened by a</p> <p>15 urinalysis.</p> <p>16 Q. Right.</p> <p>17 A. Now, if the doctor, in the context</p> <p>18 of that screen, finds hematuria, he's going to be</p> <p>19 concerned because of the presence of hematuria,</p> <p>20 and, yes, his anxiety may be heightened by the</p> <p>21 occupational or whatever social exposure to known</p> <p>22 carcinogen entities, yes, but that's -- and all</p> <p>23 that means is that he might, with greater alacrity,</p> <p>24 send him to <del>the office</del> for evaluation.</p> <p>25 Q. Okay. My question is, for example,</p>	<p>66</p> <p>1 Q. Now, would you also -- in the</p> <p>2 context of setting up a program, for example, of a</p> <p>3 group of workers that are directly in contact with</p> <p>4 the aniline dye chemical in an aniline dye</p> <p>5 manufacturing facility, and we're talking about,</p> <p>6 now, constructing a program, would you agree</p> <p>7 that -- you've already indicated that you would</p> <p>8 agree a urinalysis would be a good</p> <p>9 recommendation --</p> <p>10 A. That's correct.</p> <p>11 Q. -- in terms of screening. Now, once</p> <p>12 urinalysis is performed, if urinalysis is negative</p> <p>13 for blood --</p> <p>14 A. Right.</p> <p>15 Q. -- for hematuria, then you would</p> <p>16 recommend no further screening or monitoring for</p> <p>17 bladder cancer, correct?</p> <p>18 A. That's correct.</p> <p>19 Q. Now, assuming, in such a program, a</p> <p>20 finding positive for hematuria, would you then</p> <p>21 recommend further diagnostic testing?</p> <p>22 A. For him or anyone else; that's</p> <p>23 correct.</p> <p>24 Q. Okay. And you would not be opposed</p> <p>25 in that instance to the use of NMP-22 or cytology;</p>	<p>68</p>
<p>1 in the case of a person who -- or a group of</p> <p>2 people, for example, that work in a particular</p> <p>3 aniline dye manufacturing facility --</p> <p>4 A. Minimum.</p> <p>5 Q. -- would you recommend that that</p> <p>6 group of people be screened, outside of a normal</p> <p>7 annual physical checkup, for bladder cancer?</p> <p>8 A. One has to say, in general, of</p> <p>9 course, of course. But how long is the exposure?</p> <p>10 How great is the exposure? These are all variables</p> <p>11 that have to be brought into the --</p> <p>12 Q. Okay. You wouldn't oppose screening</p> <p>13 people who work in an aniline dye manufacturing</p> <p>14 facility being screened; correct?</p> <p>15 A. I wouldn't, but the secretary on the</p> <p>16 fifth floor is not necessarily exposed to the dyes.</p> <p>17 Q. Okay. So would it be your opinion</p> <p>18 that if there is an established or known exposure</p> <p>19 to a cancer-causing chemical, that you would not</p> <p>20 oppose recommendations of screening for that person</p> <p>21 or groups of people similarly situated?</p> <p>22 MR. WATTLEWORTH: Object to form.</p> <p>23 A. If the screening is just a</p> <p>24 urinalysis, I have no problem with that.</p> <p>25 BY MR. LEGER:</p>	<p>67</p> <p>1 correct?</p> <p>2 A. Not at all.</p> <p>3 Q. Okay. Have you provided any written</p> <p>4 materials -- and, again, we're back to Exhibit</p> <p>5 No. 1 -- any written materials, documents,</p> <p>6 writings, or other objects to counsel for</p> <p>7 R.J. Reynolds or other tobacco companies in</p> <p>8 connection with your expert testimony in this case?</p> <p>9 A. Not beyond what you have a copy of.</p> <p>10 Q. Now, in connection with this -- with</p> <p>11 your report --</p> <p>12 MS. WIMBERLY: I don't think you've</p> <p>13 identified the report --</p> <p>14 MR. LEGER: Oh, okay.</p> <p>15 MS. WIMBERLY: -- as an exhibit yet,</p> <p>16 Walter.</p> <p>17 MR. LEGER: Might as well identify</p> <p>18 it just for the sake of -- because I put all those</p> <p>19 numbers on those little tags. Might as well use</p> <p>20 them.</p> <p>21 MR. WATTLEWORTH: Yeah, I think you</p> <p>22 just have to identify the reliance list.</p> <p>23 MS. DESUE: And the CV.</p> <p>24 MR. WATTLEWORTH: Yeah.</p> <p>25 MR. LEGER: Oh, I'm sorry. This is</p>	<p>69</p>

<p>1 probably your copy that I just pulled off the 2 table.</p> <p>3 MR. WATTLEWORTH: I believe it is.</p> <p>4 MR. LEGER: Is that because you — 5 you got a tag across the top, so —</p> <p>6 MR. WATTLEWORTH: Yeah, yeah, that's 7 mine. Do we have another copy of it anywhere? I 8 mean —</p> <p>9 MS. DESUE: Let me see if I've got 10 another copy.</p> <p>11 MR. WATTLEWORTH: — we can make a 12 copy of it. That's okay.</p> <p>13 MR. LEGER: I'm sorry. I don't —</p> <p>14 MS. DESUE: I don't have a blank 15 copy. I stupidly wrote on mine, but I have one.</p> <p>16 MR. LEGER: I object to your 17 characterization as your writing —</p> <p>18 MS. DESUE: Being stupid.</p> <p>19 MR. LEGER: — being stupid, yeah. 20 And I know you really didn't mean it, for the 21 record, Chris.</p> <p>22 MS. DESUE: No, I didn't really.</p> <p>23 BY MR. LEGER: 24 In any event, we're going to attach 25 a copy of that report, Doctor, and I assume — and</p>	<p>70</p> <p>1 Q. Did he make any changes? 2 A. Yes. We made some typographical 3 changes and asked me to clarify my feelings about 4 the — specifically about the screening evaluation 5 for which individuals in particular.</p> <p>6 Q. What part of that — of your report 7 would that be? The —</p> <p>8 A. Fourth —</p> <p>9 Q. — fourth paragraph?</p> <p>10 A. — paragraph down.</p> <p>11 Q. So he suggested that you add on that 12 last sentence; is that correct?</p> <p>13 MR. WATTLEWORTH: Hold on a second. 14 Let me see — take a look at this.</p> <p>15 A. In the context of, did I know of 16 any —</p> <p>17 BY MR. LEGER: 18 Q. Right. 19 A. — recommended cancer screening — 20 MR. WATTLEWORTH: Wait. I'm — 21 A. — specifically for smokers, no. 22 MR. WATTLEWORTH: Okay. Just so I'm 23 clear, since I didn't have this report in front of 24 me when you asked that question — 1, 2, 3 — 25 fourth paragraph, you're saying — your question</p>
<p>1 mine is marked, also, but I'm talking about this 2 report.</p> <p>3 A. Correct.</p> <p>4 Q. — correct?</p> <p>5 MR. WATTLEWORTH: And you're free to 6 use mine to refer to for now —</p> <p>7 MR. LEGER: Okay. Yeah, if you 8 would.</p> <p>9 MR. WATTLEWORTH: — if you want, if 10 it'll speed things along.</p> <p>11 MR. LEGER: Thank you.</p> <p>12 MS. WIMBERLY: And, Walter, that's 13 going to be Exhibit 4?</p> <p>14 MR. LEGER: That will be Exhibit 15 No. 4 we're identifying — marked for 16 identification as Cockburn No. 4.</p> <p>17 BY MR. LEGER: 18 Q. Doctor, was that report typed in 19 your office?</p> <p>20 A. Yes, it was.</p> <p>21 Q. Okay. Was — before a final draft 22 was prepared, was it sent to anyone for review?</p> <p>23 A. Yes, it was.</p> <p>24 Q. Who was it sent to?</p> <p>25 A. Mr. Wattleworth.</p>	<p>71</p> <p>1 was, did I suggest that he add that last sentence 2 on there? Is that what your question is?</p> <p>3 MR. LEGER: Yeah. I'm not asking 4 you, though.</p> <p>5 MR. WATTLEWORTH: I know you're not, 6 but I didn't have the report, so — and he said — 7 okay. And his answer was no. Okay.</p> <p>8 MR. LEGER: Well, I'm not sure that 9 was his answer.</p> <p>10 MR. WATTLEWORTH: The problem is, 11 now that I've given you my report, I don't have a 12 copy to look at.</p> <p>13 MR. LEGER: I'm sorry. Take all the 14 time you need, Counsel, before you answer that 15 question.</p> <p>16 MR. WATTLEWORTH: Go ahead.</p> <p>17 BY MR. LEGER: 18 Q. No, I'm simply wondering, did he ask 19 you to give the opinion on that subject matter? 20 I'm not trying to play games.</p> <p>21 A. Yeah, I know. He asked me my 22 opinion on that, do I know —</p> <p>23 Q. Lawyers do that, and I'm not even 24 saying there's anything wrong with that. I'm just 25 wondering —</p>

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<p>1 A. Okay.</p> <p>2 Q. -- if he asked you to add that -- an</p> <p>3 opinion on that subject.</p> <p>4 A. He asked for my opinion on that</p> <p>5 subject, yes.</p> <p>6 Q. Okay. And your opinion, as it</p> <p>7 states, is that you're not aware of a medical</p> <p>8 association which advocates bladder cancer</p> <p>9 screening for smokers who are asymptomatic or</p> <p>10 without hematuria --</p> <p>11 A. Correct.</p> <p>12 Q. -- correct? And you've already</p> <p>13 given the opinion that you have no problem with</p> <p>14 those exposed to environmental cancer-causing</p> <p>15 agents being screened if they have hematuria;</p> <p>16 correct?</p> <p>17 A. That's correct.</p> <p>18 Q. Okay. Are you aware of any major</p> <p>19 medical associations which advocate against bladder</p> <p>20 cancer screening for smokers, period?</p> <p>21 A. No.</p> <p>22 Q. Or questionable, rather. Are you</p> <p>23 aware of any major medical association which</p> <p>24 advocates against bladder cancer screening for</p> <p>25 smokers with hematuria?</p>		<p>1 opposed; correct.</p> <p>2 Q. You would agree, generally, that</p> <p>3 cystoscopy is not a recommended form of screening,</p> <p>4 period; correct?</p> <p>5 MR. WATTLEWORTH: Object to the</p> <p>6 form.</p> <p>7 A. See, we're --</p> <p>8 BY MR. LEGER:</p> <p>9 Q. Yes.</p> <p>10 A. -- skipping around the word</p> <p>11 "screening" here --</p> <p>12 Q. Yes. Okay.</p> <p>13 A. -- and, again, I believe that the</p> <p>14 urinalysis is the screening test.</p> <p>15 Q. Okay.</p> <p>16 A. Okay? You are guilty until proven</p> <p>17 otherwise if you have blood in your urine, and</p> <p>18 it's --</p> <p>19 Q. Right.</p> <p>20 A. -- my responsibility to find the</p> <p>21 tumor, so yes.</p> <p>22 Q. That's the threshold primary</p> <p>23 screen --</p> <p>24 A. That's correct.</p> <p>25 Q. -- correct -- urinalysis?</p>		
		75		77
<p>1 A. No.</p> <p>2 Q. Now, you are aware that there are</p> <p>3 groups or organizations that advocate against</p> <p>4 cystoscopy as a method of screening; correct?</p> <p>5 MR. WATTLEWORTH: Object to the</p> <p>6 form.</p> <p>7 A. Screening for whom?</p> <p>8 BY MR. LEGER:</p> <p>9 Q. Screening for bladder cancer.</p> <p>10 A. In patients who are --</p> <p>11 Q. In an asymptomatic patient.</p> <p>12 A. Without hematuria?</p> <p>13 Q. Yes, sir.</p> <p>14 A. I'm also against that.</p> <p>15 Q. Okay. And why?</p> <p>16 A. What's the need?</p> <p>17 Q. Okay. The -- okay. My next</p> <p>18 question is, would you also oppose the use of</p> <p>19 cystoscopy in screening in a person exposed to</p> <p>20 environmental carcinogens who have no symptoms?</p> <p>21 A. And when you say -- again, is that</p> <p>22 using cystoscopy for that screening?</p> <p>23 Q. Yes.</p> <p>24 A. Without hematuria, there is very</p> <p>25 little indication for doing a cystoscopy, so I am</p>	<p>1 A. That's correct.</p> <p>2 Q. And then you work your way down the</p> <p>3 ladder and you continue to screen --</p> <p>4 A. That's correct.</p> <p>5 Q. -- and with different tests and</p> <p>6 different procedures, and at some point, even, a</p> <p>7 cystoscopy can be both a screen and/or a diagnostic</p> <p>8 tool; correct?</p> <p>9 A. When you say "screen," it is</p> <p>10 diagnostic. It is -- I don't think of it as</p> <p>11 screening.</p> <p>12 Q. Okay.</p> <p>13 A. At that point, that person is -- has</p> <p>14 something that I have to find the reason for --</p> <p>15 Q. Okay.</p> <p>16 A. -- so it's no longer a screen.</p> <p>17 Q. And, in fact, cystoscopy is</p> <p>18 invasive; correct?</p> <p>19 A. That's correct.</p> <p>20 Q. And it's quite expensive, relative</p> <p>21 to other forms of screen, like urinalysis; correct?</p> <p>22 MR. WATTLEWORTH: Object to the</p> <p>23 form.</p> <p>24 A. I don't know what the cost of an</p> <p>25 NMP-22 is, but I think cystoscopy costs as much as</p>			

<p>1 a cytology does.      2 BY MR. LEGER:      3 Q. Okay. How much does --      4 A. Cytology?      5 Q. -- cystoscopy --      6 A. Cystoscopy?      7 Q. -- cost? Forgive my -- I'm really      8 having trouble with this word, and I've been      9 practicing, Doctor.      10 A. Sure. "Cyst-o-scope-y".      11 Q. "Cyst" --      12 A. "Cysto" is for bladder --      13 Q. -- "o-scope-y."      14 A. -- and "scopy" is to look. Now I      15 forgot the question.      16 Q. So did I, Doctor. The cost --      17 A. Oh, oh.      18 Q. -- of cystoscopy.      19 A. I think Medicare pays about \$120 for      20 it.      21 Q. How long does it take?      22 A. Less than ten minutes.      23 Q. Generally outpatient?      24 A. Almost always.      25 Q. And you have no materials, no   </p>	<p>78</p> <p>1 A. Mailed.      2 Q. Or fax or otherwise?      3 A. Faxed and then mailed.      4 Q. Okay. Do you keep copies of your      5 fax receipts and that type of thing?      6 A. No.      7 Q. Have you made any speeches or public      8 statements or participated in any lectures in      9 connection with bladder cancer?      10 A. Yes.      11 Q. Where and when?      12 A. The last one was in February of this      13 year in a forum sponsored by a drug company for a      14 health fair for African-American males.      15 Q. And you spoke about bladder cancer?      16 A. (Deponent nods head.)      17 Q. Was that --      18 A. Bladder and prostate cancer.      19 Q. Did you prepare a paper?      20 A. I had notes, but I didn't -- I spoke      21 extemporaneously.      22 Q. Okay. Did you keep your notes?      23 A. No.      24 Q. What was the general gist of the      25 discussion?   </p>
<p>1 documents whatsoever, directly related to either      2 Ms. Jackson or Ms. Scott?      3 A. No, sir.      4 Q. Do you have any correspondence with      5 the lawyers for Reynolds or other tobacco      6 companies, including but not limited to, electronic      7 mail?      8 A. No.      9 Q. You did not communicate by Internet?      10 A. No.      11 Q. They send you any letters other than      12 enclosure-type letters?      13 A. None.      14 Q. Did they send you enclosure letters?      15 A. Enclosure letters, yes.      16 Q. Enclosed is a copy of?      17 A. Correct.      18 Q. Did you send them any, enclosed is a      19 copy of?      20 A. No, other than the report.      21 Q. Did the report have an enclosure      22 letter with it or did you just send it to them?      23 A. No, I just sent it.      24 Q. You mailed it to them or sent it by      25 Internet?   </p>	<p>79</p> <p>1 A. How we contribute to our health or      2 unhealth; basically, just diet, nutrition,      3 exercise, da-da-da-da-da-da.      4 Q. Did you talk about smoking?      5 A. Of course.      6 Q. Did you point out that smoking is a      7 high risk factor in both prostate and bladder      8 cancer?      9 MR. WATTLEWORTH: Object to the      10 form.      11 A. I mentioned that it is a risk      12 factor, but far more so for heart disease and      13 impotence, which concerns most men.      14 BY MR. LEGER:      15 Q. Is smoking a factor in impotence?      16 A. Yes, sir.      17 Q. A major factor?      18 A. A contributing factor.      19 Q. What's the etiology of that? You're      20 right; it is of interest.      21 A. Only in that studies have shown that      22 there's an accelerated arteriosclerotic component      23 to heart disease in smokers, and that is the bottom      24 baseline of heart disease.      25 Q. Did you talk about smoking being a   </p>

<p>1 major risk factor in connection with lung cancer?</p> <p>2 MR. WATTLEWORTH: Object to the</p> <p>3 form.</p> <p>4 A. No.</p> <p>5 BY MR. LEGER:</p> <p>6 Q. What are the known and</p> <p>7 scientifically accepted risk factors in connection</p> <p>8 with bladder cancer?</p> <p>9 A. You're talking about environmental</p> <p>10 and industrial exposure?</p> <p>11 Q. I'm talking about whatever risk</p> <p>12 factors the medical community and scientific</p> <p>13 community consider.</p> <p>14 A. Well, the most common cause of</p> <p>15 bladder cancer in the world is schistosomiasis.</p> <p>16 Q. Which is what?</p> <p>17 A. Which is an infection with the</p> <p>18 schistosoma larvae, which then enters your vascular</p> <p>19 system and then comes with the larvae in your</p> <p>20 bladder. That causes chronic inflammation and,</p> <p>21 eventually, development of squamous cell carcinoma</p> <p>22 of the bladder.</p> <p>23 Q. Okay. How about in the United</p> <p>24 States?</p> <p>25 A. In the United States, there's a very</p>	<p>82</p> <p>1 A. That's correct.</p> <p>2 Q. In your deposition in the Engles</p> <p>3 case, you indicated that you had relied upon about</p> <p>4 40 or 50 documents or articles or journals in</p> <p>5 connection with the opinions you gave in that case;</p> <p>6 is that correct?</p> <p>7 A. That's correct.</p> <p>8 Q. Did you rely upon those in the</p> <p>9 context of the opinions you've given in this case</p> <p>10 as well?</p> <p>11 A. Not to have specifically reviewed</p> <p>12 them, but the general knowledge that I got from</p> <p>13 them.</p> <p>14 Q. What did the -- what was the subject</p> <p>15 matter, generally, of that group of articles? I</p> <p>16 assume it was somewhat different than the subject</p> <p>17 matter of these.</p> <p>18 A. Well, there's a problem defining</p> <p>19 what is carcinogenic and what is not, relative to</p> <p>20 bladder cancer, and the multiple sources of</p> <p>21 carcinogens in the environment that contribute to</p> <p>22 the development of cancer and the incidence of</p> <p>23 cancer in certain individuals in certain parts of</p> <p>24 the country --</p> <p>25 Q. Mm-hmm.</p>	<p>84</p>
<p>1 high association of bladder cancer in areas in</p> <p>2 which there is a major industrial petroleum</p> <p>3 industry with distillation and refineries. New</p> <p>4 Jersey, Louisiana have high incidence of bladder</p> <p>5 cancer in that association.</p> <p>6 The aniline dye industry has always</p> <p>7 been known to be involved with it. Smoking, we</p> <p>8 know, has a higher incidence of bladder cancer in</p> <p>9 individuals who smoke heavily over a long period of</p> <p>10 time. Just about anything that has to do with</p> <p>11 hydrocarbons -- people who are involved, let's say,</p> <p>12 in motor pools of truck companies, bus companies,</p> <p>13 even taxi drivers -- have a higher incidence of</p> <p>14 bladder cancer.</p> <p>15 Q. What -- by the way, what is aniline</p> <p>16 dye?</p> <p>17 A. Aniline is a -- hmm. It's a</p> <p>18 component of dyes.</p> <p>19 Q. Of all dyes, generally, or most</p> <p>20 dyes?</p> <p>21 A. No, most dyes.</p> <p>22 Q. And aniline is the chemical in the</p> <p>23 dye that --</p> <p>24 A. That's correct.</p> <p>25 Q. -- is believed to be carcinogenic?</p>	<p>83</p> <p>1 A. -- and the complexity of it all,</p> <p>2 such that we don't still know what is the actual</p> <p>3 causative factor of bladder cancer relative to,</p> <p>4 say, smoking.</p> <p>5 Q. Okay. So my understanding what</p> <p>6 you're saying is that in the Engle case, the issue</p> <p>7 that you dealt with was whether or not smoking</p> <p>8 causes bladder cancer?</p> <p>9 A. That's correct.</p> <p>10 Q. And your opinion was that there</p> <p>11 isn't sufficient scientific data to establish</p> <p>12 smoking as the cause of bladder cancer; correct?</p> <p>13 A. That's correct.</p> <p>14 Q. But you also agreed that smoking is</p> <p>15 a known cause of bladder cancer --</p> <p>16 A. Definitely.</p> <p>17 Q. -- correct? And you also agreed in</p> <p>18 that case that cigarette smoking significantly</p> <p>19 increases the risk in a person to bladder cancer</p> <p>20 over that of a normal -- over that of a nonsmoker;</p> <p>21 correct?</p> <p>22 MR. WATTLEWORTH: Object to the</p> <p>23 form.</p> <p>24 A. With the only modification of the</p> <p>25 amount of smoking and the duration of smoking.</p>	<p>85</p>

<p>1 BY MR. LEGER:</p> <p>2 Q. The -- is it your testimony that the 3 scientific data suggests that the incidence of 4 bladder cancer in smokers is relative to duration 5 of smoking and the amount of cigarettes they smoke?</p> <p>6 A. Correct.</p> <p>7 Q. So there is a dose response, 8 effectively --</p> <p>9 A. That's correct.</p> <p>10 Q. -- correct? And that's true of many 11 carcinogens in the context of causation and cancer; 12 correct?</p> <p>13 A. That's correct.</p> <p>14 Q. In fact, that's one of the principal 15 characteristics of a carcinogen; correct? The 16 chance of developing cancer is related to dose and 17 response?</p> <p>18 A. That's correct.</p> <p>19 Q. Doctor, I'm going to refer you to 20 your curriculum vitae at this time -- you probably 21 don't need to look at it, but I do -- and just ask 22 you a few questions there. You have some 23 special training in urological oncology; 24 correct?</p> <p>25 A. I do.</p>	<p>86</p> <p>1 A. Well, yes, you could call cystoscopy 2 surgery, but it's -- I don't consider it surgery 3 unless I cut something --</p> <p>4 Q. Okay.</p> <p>5 A. -- in the course of cystoscopy. If 6 you have a bladder tumor, I'll -- I can remove it 7 through the cystoscope, and that is a surgical 8 procedure. The actual --</p> <p>9 Q. Is that called a cystectomy --</p> <p>10 A. No.</p> <p>11 Q. -- or is that different?</p> <p>12 A. Cystectomy means removing the whole 13 bladder.</p> <p>14 Q. Ah, okay.</p> <p>15 A. Okay? Here would just be a tumor 16 resection. It would be cystoscopy with tumor 17 resection.</p> <p>18 Q. Okay.</p> <p>19 A. And then that has to be performed 20 under anesthesia -- general anesthesia.</p> <p>21 Q. Okay. And are those the forms of 22 surgery that you do today?</p> <p>23 A. Yes. I am -- or if the patient were 24 to have invasive bladder cancer, he would have to 25 have his bladder removed, and then make him a new</p>
<p>1 Q. And would you tell me about that 2 training?</p> <p>3 A. It's a clinical fellowship I did at 4 the Memorial Sloan Kettering Hospital in New York 5 from 1980 to 1981 in which my clinical research 6 actually was looking for bladder tumor antigens in 7 the urine and -- but that was the laboratory research. My clinical was -- basically was surgery 9 of the bladder, kidney, prostate.</p> <p>10 Q. What does that mean, your clinical 11 was surgery? You actually performed surgery?</p> <p>12 A. I did the surgery, yes.</p> <p>13 Q. Do you do surgery now?</p> <p>14 A. Oh, yes.</p> <p>15 Q. Now, by surgery, you include -- in 16 the definition of surgery, we often think -- we lay 17 people think of surgery as cutting with a knife.</p> <p>18 A. That's correct.</p> <p>19 Q. But there's also other forms of 20 surgery --</p> <p>21 A. Right.</p> <p>22 Q. -- like cystoscopy?</p> <p>23 A. Right.</p> <p>24 Q. That is what you call surgery. And 25 what else? What other types of surgery do you do?</p>	<p>87</p> <p>1 A. bladder out of his colon. That's part of my 2 surgery, too.</p> <p>3 Q. And you do that type of surgery, 4 also.</p> <p>5 In the context of your curriculum 6 vitae, at Columbia you were an assistant professor 7 of urology. What does that mean?</p> <p>8 A. Well, it's a step above --</p> <p>9 Q. What's an assistant professor?</p> <p>10 A. -- a step above instructor and one 11 below associate professor.</p> <p>12 Q. Okay. I mean, did you teach 13 classes?</p> <p>14 A. No. In that context, a clinician or 15 an academician is teaching medical students in the 16 hospital, not in a didactic setting in a classroom 17 per se.</p> <p>18 Q. Mn-hmm.</p> <p>19 A. You teach them on rounds, you teach 20 them in the operating room -- in that way.</p> <p>21 Q. So while in that capacity, you were 22 basically an employee of the hospital or the 23 medical school?</p> <p>24 A. Yes.</p> <p>25 Q. And not in private practice?</p>

<p>1 A. That's correct.</p> <p>2 Q. Okay. Now, since 1985, you've been 3 at the University of Florida in Tampa; correct?</p> <p>4 A. South Florida, yes.</p> <p>5 Q. I'm sorry. South Florida in Tampa. 6 And -- but you have also been in private practice; 7 is that right?</p> <p>8 A. Right. So my association with the 9 university is a clinical appointment, and that 10 means I don't get paid but I do pretty much the 11 same thing in terms of teaching residents.</p> <p>12 Q. So you don't stand up in front of a 13 classroom of med students and lecture them --</p> <p>14 A. No.</p> <p>15 Q. -- with a blackboard and that kind 16 of thing?</p> <p>17 A. No.</p> <p>18 Q. And so do I understand that 19 basically you have privileges at the University of 20 South Florida Medical Center or some facility?</p> <p>21 A. Tampa General Hospital, which is 22 their main teaching hospital, yes.</p> <p>23 Q. I mean is there an actual 24 University of South Florida medical school?</p> <p>25 A. No.</p>	<p>90</p> <p>1 A. No. When you have "clinical" in 2 front of it, you're not being paid.</p> <p>3 Q. Okay. And so you go from professor, 4 assistant professor, associate professor, and then 5 clinical assistant professor; correct? That's --</p> <p>6 A. You can be a clinical associate or 7 clinical professor, too.</p> <p>8 Q. Okay. That's enough for me. It's 9 getting beyond my mental capacity to understand.</p> <p>10 The Tampa General Hospital, I 11 assume, is not the only hospital at which you have 12 privileges today --</p> <p>13 A. That's correct.</p> <p>14 Q. -- correct? And those privileges 15 are listed under --</p> <p>16 A. Yes.</p> <p>17 Q. -- hospital affiliations? Now, I'm 18 also -- I'm looking at unpublished presentations at 19 major medical meetings, and you list -- 1, 2 -- 20 three. Do any of them have to do with bladder 21 cancer?</p> <p>22 A. No.</p> <p>23 Q. Any of them have to do with cancer 24 at all? If you want to --</p> <p>25 A. Yes, all were involved with</p>
<p>1 Q. Okay. Are there any professors of 2 urology at the University of South Florida?</p> <p>3 A. Yes.</p> <p>4 Q. Are they paid, also -- are they 5 paid?</p> <p>6 A. They are paid.</p> <p>7 Q. Okay. A clinical assistant 8 professor is not correct?</p> <p>9 A. Correct.</p> <p>10 Q. Would an assistant professor be 11 paid?</p> <p>12 A. Yes.</p> <p>13 Q. And there are --</p> <p>14 A. Yes.</p> <p>15 Q. -- assistant professors?</p> <p>16 A. Yes.</p> <p>17 Q. And those people, either a professor 18 or an assistant professor, do not have private 19 practices?</p> <p>20 A. Correct.</p> <p>21 Q. Okay. And the next step -- 22 professor or assistant professor -- is there an 23 associate professor?</p> <p>24 A. Yes.</p> <p>25 Q. And is that person paid?</p>	<p>91</p> <p>1 Q. Okay. Are there any professors of 2 urology at the University of South Florida?</p> <p>3 A. Yes.</p> <p>4 Q. Are they paid, also -- are they 5 paid?</p> <p>6 A. They are paid.</p> <p>7 Q. Okay. A clinical assistant 8 professor is not correct?</p> <p>9 A. Correct.</p> <p>10 Q. Would an assistant professor be 11 paid?</p> <p>12 A. Yes.</p> <p>13 Q. And there are --</p> <p>14 A. Yes.</p> <p>15 Q. -- assistant professors?</p> <p>16 A. Yes.</p> <p>17 Q. And those people, either a professor 18 or an assistant professor, do not have private 19 practices?</p> <p>20 A. Correct.</p> <p>21 Q. Okay. And the next step -- 22 professor or assistant professor -- is there an 23 associate professor?</p> <p>24 A. Yes.</p> <p>25 Q. And is that person paid?</p> <p>93</p> <p>1 A. cancers. The first one was the germ cell tumors of 2 the testicle, the second was treatment of prostatic 3 carcinoma, and the third one was also germ cell 4 tumors of the testicle.</p> <p>5 Q. None of these articles had anything 6 to do with medical screening or diagnosis in 7 relation to bladder cancer; correct?</p> <p>8 A. That's correct.</p> <p>9 Q. None of them had to do with the 10 analysis of -- or principles of screening, or 11 particularly the tools of screening or otherwise --</p> <p>12 A. No.</p> <p>13 Q. -- correct? And in the context of 14 your publications, may I assume that the last 15 publication you were involved in was 1984?</p> <p>16 A. That's correct.</p> <p>17 Q. And none of those publications had 18 to do with bladder cancers, except for perhaps 19 No. 6?</p> <p>20 A. That's correct.</p> <p>21 Q. And that was in 1984?</p> <p>22 A. That's correct.</p> <p>23 Q. Was there any analysis in that 24 article of predicting tools?</p> <p>25 A. No. They weren't available at that</p>

	94	
1	time.	
2	Q. So these tests that we talked about	
3	and that you talked about, really, in your	
4	report - NMP-22, BTA Stat, FDP, Telomerase assay,	
5	and others - and the search for markers in P 53	
6	gene, etc. - are relatively new developments, in	
7	the '90s, perhaps?	
8	A. That's correct.	
9	Q. Particularly, the latter part of the	
10	'90s; correct?	
11	A. That's correct.	
12	Q. Do you particularly have any opinion	
13	as to whether or not there are currently very	
14	promising emerging technologies in the context of	
15	laboratory tests to predict and find bladder tumor?	
16	A. Beyond those that were mentioned	
17	here?	
18	Q. Yes, sir.	
19	A. I'm certain that there are. I	
20	know that there are. Now that the human genome	
21	project has been completed, there are a number of	
22	different markers that are being exploited to look	
23	into what really is cancer, how cancer starts from	
24	the beginning, what are the signals that turn them	
25	on; and then as we learn more about the signals,	
	95	
1	where we can modulate them or -- and gain further	
2	insight into what we want to know, mostly not so	
3	much as whether or not there is a cancer there as	
4	what is the malignant potential of that cancer in	
5	particular, how scrupulously do we have to monitor	
6	that patient?	
7	Q. By "scrupulously," you mean how	
8	closely you should monitor for fear of growth of --	
9	A. No.	
10	Q. -- spreading --	
11	A. We have to do cystoscopy on every	
12	single one of them every three months. We're	
13	trying to reduce the number of cystoscopies that we	
14	have to do, for all of the reasons you mentioned	
15	before.	
16	Q. What you would prefer to do in a	
17	patient with a high risk of bladder cancer or a	
18	malignant tumor is to monitor in some way by	
19	laboratory test as opposed to continue to do	
20	periodic cystoscopies; right?	
21	A. Yes and no, but, you see, you still	
22	have to do the cystoscopy. If the tumor marker	
23	comes back positive, what you might do is, instead	
24	of saying, Listen, I'm going to -- I want to see	
25	you in my office in three months, you schedule them	
	96	
1	for the hospital in three months so that you do	
2	your cystoscopy under anesthesia because you may be	
3	resecting a tumor at that time. That way, you	
4	obviate the need for doing it twice.	
5	Q. Okay. And the importance, then, of	
6	the other diagnostic tools, the laboratory tools,	
7	are to, prior to that scheduling in the hospital in	
8	six months, be able to monitor progress, etc.; is	
9	that correct?	
10	A. That's correct.	
11	Q. Now, other than the deletion of	
12	manuscript in preparation on your curriculum vitae,	
13	no other significant changes that we ought to be	
14	aware of; correct?	
15	A. No, other than the change of the	
16	name of the hospital on page 2 on the bottom from	
17	Centurian Hospital is now University Community	
18	Hospital. Same hospital, different name.	
19	Q. Okay. An attending urologist just	
20	means that you're a urologist in private practice	
21	that has privileges at the hospital?	
22	A. Privileges to practice at the	
23	hospital; correct.	
24	Q. Now, by "private practice," I assume	
25	that means you have a private office that has your	
	97	
1	name on it --	
2	A. That's correct.	
3	Q. -- the offices of Dr. Cockburn?	
4	A. Correct.	
5	Q. Do you have any particular	
6	checklists or forms that you have patients	
7	themselves prepare in context of history or	
8	otherwise --	
9	A. Yes, I do.	
10	Q. -- when they come to your office?	
11	Can we -- we asked for that -- I believe we	
12	did -- and I believe that's what this is in here,	
13	and I was wondering if we can get a copy of those.	
14	A. You certainly can.	
15	MS. WIMBERLY: Walter, which part of	
16	the subpoena are you referring to?	
17	MR. LEGER: That would be No. 25 --	
18	well, I'm sorry. No, it's not No. 25. It's	
19	No. 24 -- no, no, I take that back. Let me look at	
20	it.	
21	MS. DESUE: I think it's -- keep	
22	going.	
23	MR. LEGER: Yeah, it's No. 28. And	
24	actually what I'm looking for is 28, 29,	
25	ultimately, and I'm going to ask about that.	

<p>1                   MR. WATTLEWORTH: So right now 2 you're wanting the history? You're asking for the 3 history?</p> <p>4                   MR. LEGER: Actually, I want 5 everything we asked for.</p> <p>6                   MR. WATTLEWORTH: Yeah.</p> <p>7                   MR. LEGER: But I'm asking 8 specifically —</p> <p>9                   MR. WATTLEWORTH: Right now, you're 10 talking about the history.</p> <p>11                  MR. LEGER: — just now about what 12 the patient fills out.</p> <p>13                  MS. WIMBERLY: I think we have given 14 you everything other than the billing, and then, 15 quite frankly, this is something that I don't think 16 any of us had ever focused on in the context of the 17 subpoenas.</p> <p>18                  MR. LEGER: Okay. Well, except 19 that -- and I'm not talking with you, except that 20 this subpoena form is a form that you sent to our 21 witnesses that we subpoenaed. And I don't mean 22 that you did, Ms. Wimberly, but lawyers for the 23 tobacco companies sent, I would suggest 24 obnoxiously, to some of our first witnesses, and we 25 don't -- we obviously don't mean it obnoxiously.</p>	<p>98.</p> <p>1                   I start a controversy or even document a controversy 2 other than just I want to confirm that we — I 3 don't think we've had any real firm agreement other 4 than I thought we agreed to provide everything 5 three days prior to, and we've been attempting to.</p> <p>6                   MS. WIMBERLY: And our understanding 7 was simply three days prior we were providing 8 reliance and attempting to provide prior testimony 9 and files, but —</p> <p>10                  MR. LEGER: And —</p> <p>11                  MS. WIMBERLY: And certainly this is 12 something we can get.</p> <p>13                  MR. LEGER: Yeah, right.</p> <p>14                  MS. WIMBERLY: I'm sure it's a 15 standard form.</p> <p>16                  MR. LEGER: And it's really not that 17 important in all of them. We've been using these 18 forms as pertinent.</p> <p>19                  BY MR. LEGER:</p> <p>20                  Q. And I guess, in particular, Doctor, 21 let me ask you about that. In the form in your 22 office that the patient is asked to fill out — and 23 I assume it's like the typical doctor's — there's, 24 like, a clipboard or something, and there's some 25 form; you sit there and you fill it out yourself?</p>
<p>1                  We just thought that since you guys were interested 2 in them, we ought to be interested in them, too.</p> <p>3                  MR. WATTLEWORTH: Can we just agree 4 that --</p> <p>5                  MR. LEGER: And we can strike that 6 colloquy, if you --</p> <p>7                  MS. WIMBERLY: And I might tell you, 8 Walter, we haven't seen a single one from any of 9 plaintiffs' witnesses, and I think everybody's 10 just kind of overlooked that particular item.</p> <p>11                  MR. WATTLEWORTH: I was going to 12 suggest that perhaps we handle the request on the 13 subpoena consistently with how we've been handling 14 them up to this point.</p> <p>15                  MR. LEGER: Well, I would suggest we 16 not, because there hasn't -- there's been nothing 17 consistent about it.</p> <p>18                  MR. WATTLEWORTH: I mean, it sounds 19 like --</p> <p>20                  MR. LEGER: But I think, generally, 21 we have been trying to -- we've been trying to get 22 consistent.</p> <p>23                  MR. WATTLEWORTH: Okay. Well, 24 we'll --</p> <p>25                  MR. LEGER: And I'm not trying to</p>	<p>99.</p> <p>1                  A. Four pages.</p> <p>2                  Q. Four pages. Is there any question 3 regarding smoking history?</p> <p>4                  A. Yes.</p> <p>5                  Q. And what does that involve? Does it 6 just ask, Do you smoke, or --</p> <p>7                  A. Do you smoke and how much and, if 8 you stopped, how long ago.</p> <p>9                  Q. And is that a form that you 10 developed yourself?</p> <p>11                  A. Yes.</p> <p>12                  Q. And why is that on the form?</p> <p>13                  A. It's important.</p> <p>14                  Q. Why is it important?</p> <p>15                  A. Well, it's for all the potential 16 risk problems that have been well documented in the 17 past, you know, general health, etc.</p> <p>18                  Q. Including, particularly, the risk of 19 smoking related to bladder cancer, correct?</p> <p>20                  MR. WATTLEWORTH: Object to the 21 form.</p> <p>22                  A. Not really.</p> <p>23                  BY MR. LEGER:</p> <p>24                  Q. Okay.</p> <p>25                  A. Blood in the urine is such a red</p>

<p>1 flag to us that — for so many other things.      2 Bladder cancer may turn out to be 1 percent of all      3 the people who do have something positive in their      4 evaluation for hematuria. So it's not the first      5 thing on my mind, but as a urologist, it's up      6 there.</p> <p>7 Q. It's certainly one of the things you      8 worry about most, though, isn't it, Doctor?</p> <p>9 A. Certainly.</p> <p>10 Q. And certainly one of the things the      11 patient worries about the most; correct?</p> <p>12 A. I don't think patients worry about      13 it enough, no.</p> <p>14 Q. Okay. Doctor, let me talk to you a      15 little bit about prostate cancer and the PSA.      16 A. Okay.</p> <p>17 Q. Does the smoking present a high risk      18 factor for prostate cancer?</p> <p>19 A. Not in any epidemiological study      20 that I've noted.</p> <p>21 Q. Okay. The -- what is the -- how is      22 a PSA performed?</p> <p>23 A. Simply a blood test.      24 Q. And there's laboratory testing to      25 look for what in the blood?</p>	<p>102</p> <p>1 A. That was suggestive of the need for      2 a PSA, yes.      3 Q. And what is that?</p> <p>4 A. That's genetics, whether or not a      5 blood relative had had prostate cancer.</p> <p>6 Q. Anything else? Environmental      7 exposures? Age? Anything else?</p> <p>8 A. No. Age is almost a truism, because      9 any man — the incidence of prostate cancer rises      10 to almost 70 percent in men over the age of 80, so      11 it's common.</p> <p>12 Q. The incidence being that men —      13 that —</p> <p>14 A. There's an age-related —      15 Q. — 70 percent of prostate cancers      16 are found in men who are over 80?</p> <p>17 A. No. Put it the other way.      18 Q. That in men over 80, 70 percent of      19 them have prostate cancer?</p> <p>20 A. That's correct.</p> <p>21 Q. How about men over, like, 48?</p> <p>22 A. One in three. There are four of us      23 in here.</p> <p>24 Q. I think only two of us are over 48,      25 Doctor.</p>	<p>104</p>
<p>1 A. Looking for PSA. PSA is prostate      2 specific antigen. It's an antigen in the blood      3 that is identifiable by antibody — antigen complex      4 technique.</p> <p>5 Q. Okay. Is the PSA recommended as a      6 screening methodology to the general population of      7 males?</p> <p>8 A. Only by the American Urological      9 Association, not by the American Family Practice      10 Association.</p> <p>11 Q. Do you know why there is a      12 recommendation by the urologists but not the family      13 practice people?</p> <p>14 A. Well, it's our bailiwick. That's      15 what we are charged to protect and defend against,      16 and we see a higher incidence of it, obviously,      17 because that's our specialty, and so our concerns      18 are skewed in that direction. Family Practice      19 Association feels that the incidence of prostate      20 cancer is not high enough that warrants a general      21 statement that everyone should have it on the      22 regularity that has been proposed by the AUA.</p> <p>23 Q. Okay. Is there a particular risk      24 factor that would — in the view of the field of      25 urologists — that would be suggestive of a PSA?</p>	<p>103</p> <p>1 A. That's true.</p> <p>2 MR. WATTLEWORTH: I'll mark it on my      3 calendar.</p> <p>4 MR. LEGER: And, for the record, I'm      5 not admitting that I'm over 39. That's my story,      6 I'm sticking to it, and I'm not under oath,      7 Doctor.</p> <p>8 BY MR. LEGER:</p> <p>9 Q. As a part of your normal checkup of      10 a person — well, strike that.</p> <p>11 When a person comes to see you, are      12 they ordinarily referred by another physician for      13 the first-time visit?</p> <p>14 A. I'd say 50 percent of my practice is      15 referral, yes.</p> <p>16 Q. Where do the other 50 percent come      17 from? How do they get to you?</p> <p>18 A. When you say "referred," you mean by      19 another physician? The other 50 percent come word      20 of mouth or their own knowledge that a urologist is      21 indicated for sexual dysfunction, urinary tract      22 infections, incontinence —</p> <p>23 Q. I guess that's my question. How      24 does the ordinary person get to a urologist?</p> <p>25 A. Yeah.</p>	<p>105</p>

<p>1 Q. Is it the — 50 percent of them, you 2 said, are generally referred by perhaps a general 3 practitioner or someone who's treating them for 4 something else; correct?</p> <p>5 A. That's correct.</p> <p>6 Q. Or a general practitioner who 7 observes urological symptoms?</p> <p>8 A. That's correct.</p> <p>9 Q. The other 50 percent come to you 10 with some other reason; they even have an idea —</p> <p>11 A. Their own sophistication and 12 knowledge of medicine.</p> <p>13 Q. Okay. When you see a patient for 14 the first time, you take, I assume, a pretty 15 detailed history?</p> <p>16 A. That's correct.</p> <p>17 Q. And you — do you perform any 18 particular tests?</p> <p>19 A. Yes.</p> <p>20 Q. And I'm talking about a patient that 21 comes to you not referred for specific testing or a 22 look by another doctor —</p> <p>23 A. Yes.</p> <p>24 Q. — correct?</p> <p>25 A. Yes.</p>	<p>106</p> <p>1 A. Nothing above the waist. 2 Q. Nothing above the waist. 3 MS. DESUE: That's cute. 4 BY MR. LEGER: 5 Q. Nothing to do with the — with 6 stress testing, any cardiographic testing 7 whatsoever?</p> <p>8 A. I may stress some individuals, but, 9 no, I don't —</p> <p>10 Q. All right. You perform cystoscopy?</p> <p>11 A. I do.</p> <p>12 Q. Intravenous pyelography?</p> <p>13 A. No. I order that. That's a —</p> <p>14 Q. Okay.</p> <p>15 A. — radiological test.</p> <p>16 Q. Okay. But that's something that you 17 observe and you supervise, and it's pertinent to 18 your practice?</p> <p>19 A. That's correct.</p> <p>20 Q. CT scans?</p> <p>21 A. No.</p> <p>22 Q. What's a VAT wedge? Is that 23 something in your practice?</p> <p>24 A. No.</p> <p>25 Q. Okay. I didn't think so. Do you —</p>
<p>1 Q. What tests do you perform as a 2 matter of course?</p> <p>3 A. A physical examination, from blood 4 pressure onward, and depending on the complaint, a 5 urinalysis for everyone. If someone comes in 6 complaining of sexual dysfunction, I probably won't 7 look at his urine.</p> <p>8 Q. Okay. Do you do a PSA?</p> <p>9 A. If they're over 50 and they — if 10 they haven't had one in the past year.</p> <p>11 Q. And the — you do a PSA for 12 males over 50 is that because there is 13 statistically and epidemiologically shown a very 14 high risk of prostate cancer?</p> <p>15 A. That's correct.</p> <p>16 Q. Okay. I'm going to — do you 17 have — no, you don't have this before you. I'm 18 just going to go through a number of tests and ask 19 if you have any association in your ordinary 20 practice with performing these or reading it.</p> <p>21 You certainly don't have any 22 involvement with doing a needle biopsy of the lung; 23 correct?</p> <p>24 A. No, sir.</p> <p>25 Q. Bronchoscopy?</p>	<p>107</p> <p>1 is testing of the blood for lipids pertinent to 2 your practice?</p> <p>3 A. Not regularly.</p> <p>4 MR. LEGER: If you'd like to take a 5 break, the videotape is near the end and this is a 6 logical point. (A brief recess is taken.)</p> <p>7 BY MR. LEGER: 8 Q. Doctor, in the context of your 9 ordinary office visits with patients, if you 10 observe a smoking history of a patient, do you talk 11 to them or counsel them with regard to smoking 12 itself?</p> <p>13 A. I do, depending on the level of 14 smoking that they admit to.</p> <p>15 Q. And what form does that counseling 16 take?</p> <p>17 A. Well, if I see that they smoke 18 excessively — and to me, excessive is more than, 19 say, a half a pack a day — then I will counsel 20 them and explain to them their risks for 21 cardiovascular disease, lung problems and, 22 remotely, bladder cancer.</p> <p>23 Q. Do you — have you ever had 24 occasion, in your treatment of individuals, to</p>

<p>1 refer patients for assistance in cessation of  2 smoking?</p> <p>3 A. Have I referred — yes, I have.</p> <p>4 Q. And tell me about that.</p> <p>5 A. When someone smokes excessively and  6 is having problems from that, then I strongly  7 suggest that they stop and then recommend one of  8 the various means that are available to help them  9 stop, from Zyban to counseling.</p> <p>10 Q. Do you prescribe Zyban?</p> <p>11 A. No, I don't, because the follow-up  12 is more complex than I want to be involved with.</p> <p>13 Q. I mean, do you get to the point of  14 recommending particular modalities to assist in  15 stopping a smoker?</p> <p>16 A. I don't feel that I educate  17 them more than recommend them, and then recommend  18 them to an internist for smoking cessation.</p> <p>19 Q. You don't refer them to a  20 psychiatrist?</p> <p>21 A. No.</p> <p>22 Q. You believe that the family care  23 physician is the primary treat for  24 smoking-related problems in the context of the  25 smoking itself?</p>	<p>110</p> <p>1 in the medical and scientific community?</p> <p>2 MR. WATTLEWORTH: Object to the  3 form.</p> <p>4 A. I don't know — I specifically don't  5 know where that comes from or if it's attributable  6 to the Surgeon General. I know that smoking is an  7 addictive behavior, yes. So is eating.</p> <p>8 BY MR. LEGER:</p> <p>9 Q. So you believe that smoking is an  10 addictive behavior like eating?</p> <p>11 A. I think that anything that feels  12 good or gives pleasure is potentially addictive.</p> <p>13 Q. Okay. What is your definition of  14 addictive? Was that it?</p> <p>15 A. Mine, I guess, would be a dictionary  16 definition, and that is a physiological or  17 psychological dependence on a substance or action  18 that the individual feels incapable of stopping by  19 himself.</p> <p>20 Q. Okay. Now, you are aware that the  21 health care community has determined that nicotine  22 has psychoactive properties; correct?</p> <p>23 A. That's correct.</p> <p>24 Q. And you would also agree that  25 nicotine has reinforcing properties; correct?</p>
<p>1 A. Yes, because I see it as a  2 mechanical addiction, and I think that drug  3 therapy works fairly well with it. People -- I  4 wouldn't send them to a psychiatrist for smoking,  5 but people who smoke tend to smoke because of  6 emotional problems that they may have, so from that  7 standpoint, I will send them, and smoking is just a  8 symptom of the general pathology.</p> <p>9 Q. Do you know that the Surgeon General  10 has declared that smoking is an addictive activity?</p> <p>11 A. Of course it is.</p> <p>12 Q. And you don't disagree that nicotine  13 is the addictive agent in cigarettes?</p> <p>14 A. I think that the data — and I'm not  15 an addictologist — shows that the act of  16 smoking — and whether or not it's specifically  17 nicotine, I don't know, but — that the act of  18 smoking is habit forming and that some form of  19 addiction can occur.</p> <p>20 Q. Are you familiar with the — would  21 you agree that it is the Surgeon General's and the  22 United States Public Health Service definitions and  23 opinions regarding the addictive nature of nicotine  24 which are the factors which define the term  25 "nicotine addiction" as it is commonly used today</p>	<p>111</p> <p>1 A. What do you mean by that?</p> <p>2 Q. That the — are you familiar with  3 the term "reinforcement"?</p> <p>4 A. No.</p> <p>5 Q. The medical term? Are you an expert  6 in addiction?</p> <p>7 A. By no means.</p> <p>8 Q. Are you an expert in the field of  9 substance dependence?</p> <p>10 A. No.</p> <p>11 Q. Do you intend to offer opinions  12 regarding the addictive properties —</p> <p>13 A. No.</p> <p>14 Q. — of nicotine at trial in this  15 case?</p> <p>16 A. No, sir.</p> <p>17 Q. Have you read the Surgeon General's  18 reports regarding cigarette smoking?</p> <p>19 A. No.</p> <p>20 Q. Do you intend to?</p> <p>21 A. Excerpts of it.</p> <p>22 Q. I'm sorry?</p> <p>23 A. Excerpts, I've read, but, no, I  24 don't plan to read the whole thing.</p> <p>25 Q. Have you ever treated persons in</p>

PROSECUTOR'S BRIEFCASE

<p>114</p> <p>1 your medical practice who have problems with the 2 use of drugs such as heroin — 3 A. Yes. 4 Q. — cocaine, alcohol? 5 A. Yes. 6 Q. Do heroin or cocaine or alcohol have 7 any particular significance in the context of your 8 practice when used by patients? 9 A. Only in a complication of potential 10 anesthesia. 11 Q. Now, have you — I assume you do no 12 particular counseling with regard to patients who 13 use cocaine, alcohol, heroin, or other opiates in 14 connection with their use of those drugs? 15 A. No. 16 Q. Is there a question on your form or 17 your checklist when you see a new patient asking 18 them regarding the use of drugs? 19 A. No — yes, there is one in the 20 general form asking what drugs they are taking, 21 but — 22 Q. You don't ask, Are you using 23 heroin? Are you using cocaine? 24 A. No, I don't. 25 Q. ... How, in the ordinary course, would</p>	<p>116</p> <p>1 practice. 2 Q. My real question is that there are 3 observable features sometimes of cigarette smokers; 4 correct? 5 A. That's correct. 6 Q. Would, in the ordinary course of 7 your treatment, you make an observation in the 8 record if a person has not indicated they're a 9 smoker to you on the forms or by history, but you 10 observe characteristics of a smoker? 11 A. No. 12 Q. So the significance to you as a 13 clinician is the self-reporting aspect; correct? 14 A. Yes. 15 Q. I assume you do not intend to offer 16 yourself as an expert in pulmonology? 17 A. No, sir. 18 Q. Or in lung cancer? 19 A. No. 20 Q. Or cardiology? 21 A. No. 22 Q. Surgery above the waist? 23 A. No. 24 Q. Do you regularly treat children? 25 A. No longer. I stopped about two</p>
<p>115</p> <p>1 you — in a typical case — would you come to find 2 out that a patient is using one of those drugs? 3 A. Either I suspect it and I ask it or 4 the patient will tell me, I'm a reformed alcoholic 5 or reformed drug abuser. 6 Q. Have you in the course of your 7 practice, have you observed physical properties or 8 characteristics of smokers which suggest that they 9 are smokers, I mean in terms of you observing 10 without them telling you? 11 A. Sure. 12 Q. Sight, smell, touch? 13 A. Sure. Tobacco smoke on their 14 breath, a pack of cigarettes in their pocket, 15 yellow fingers. 16 Q. Yellow teeth? 17 A. We're in the South. 18 Q. Or stained teeth? 19 A. Yes. 20 MS. DESUE: We're in the South, you 21 said? 22 BY MR. LEGER: 23 Q. Holes in their clothing, that kind 24 of thing, from cigarette burns? 25 A. Maybe at the VA, but not in my</p>	<p>117</p> <p>1 years ago. 2 Q. And why was that? 3 A. Kind of almost turf battles now. 4 Now, there are a sufficient number of pediatric 5 urologists such as to make it less common that I 6 would see problems in children, and the — and I 7 would be only seeing the simple things, like 8 circumcisions or things like that. More difficult 9 ones would go off, and I would send them myself, to 10 the pediatric urologist. 11 Q. Okay. Do you know any of the expert 12 witnesses in this case? 13 A. None. 14 Q. Do you know Dr. Roy Wiener? 15 A. No. 16 Q. Have you met any of the defendants' 17 expert witnesses in this case? 18 A. No, I haven't. 19 Q. Do you know Dr. Malsby? 20 A. No. 21 Q. You ever heard of him? 22 A. No. 23 Q. Do you intend to be — have you been 24 told when the trial in this case will begin? 25 A. No.</p>

<p>1 Q. Do you understand that this case is 2 a class action on behalf of all Louisiana smokers? 3 A. Yes. 4 Q. And you understand that the members 5 of the class are seeking to be able to benefit from 6 a program of smoking cessation? 7 A. Okay. 8 Q. Is that your — did you know that 9 before I — 10 A. Yes. 11 Q. Okay. So you've seen the monitoring 12 program — 13 A. Yes. 14 Q. — and seen that it has several 15 parts? 16 A. Correct. 17 Q. One is a smoking cessation program; 18 correct? 19 A. Correct. 20 Q. And the other are monitoring or 21 screening provisions regarding bladder cancer, lung 22 cancer, coronary artery disease, and COPD, chronic 23 obstructive pulmonary disease; correct? 24 A. Correct. 25 Q. All right. Are you in a position to</p>	<p>118 1 this Guide to Clinical Preventive Services? 2 A. What do I know about it? 3 Q. Yes, sir. 4 A. Other than having read it? 5 Q. Yes, sir. 6 A. I don't understand the question. 7 Q. Had you ever heard of this thing 8 before — 9 A. No. 10 Q. — this case? 11 A. No. 12 Q. And so you didn't find it on your 13 own — 14 A. No. 15 Q. — did you? You didn't look it up 16 as a research source? 17 A. No. 18 Q. You were — this was given to you by 19 tobacco lawyers; right? 20 A. That's correct. 21 Q. Is — would you agree that this 22 Guide to Clinical Preventive Services is not 23 something that is ordinarily used by practicing 24 physicians? 25 MR. WATTLEWORTH: Object to the</p>
<p>1 offer opinions regarding any of the areas of the 2 medical monitoring program other than bladder 3 cancer? 4 A. No. 5 Q. Are you familiar with the provisions 6 of the Guide to Clinical Preventive Services? 7 A. I've read it. 8 Q. Is that something that you would 9 have read regularly in your practice? 10 A. No. 11 Q. Did you read it merely in connection 12 with testimony in this case; correct? 13 A. That's correct. 14 Q. And you read the provisions 15 regarding recommendations in connection with 16 bladder cancer? 17 A. Yes, sir. 18 Q. And what are those recommendations? 19 A. Oh, I'd have to read it again. 20 Q. Okay. 21 MR. LEGER: Do you have a clean copy 22 of it? 23 MS. DESUE: Yes, I do. 24 BY MR. LEGER: 25 Q. What do you know about this thing,</p>	<p>119 1 form. 2 A. As a guide, no, but the general 3 principles within are well accepted. 4 BY MR. LEGER: 5 Q. Okay. But I mean — but in terms of 6 finding the principles, to determine the 7 principles, the typical practitioner doesn't look 8 for this guide — 9 A. No. 10 Q. — is that correct? 11 MR. WATTLEWORTH: Object to form. I 12 just want to — are you talking about any 13 practitioner or a urologist? 14 MR. LEGER: I'm talking about in his 15 observation; right. 16 BY MR. LEGER: 17 Q. Okay. Well, let's break it down, 18 then. Urologists don't — when they're trying to 19 think of what are we going to do to try to prevent 20 disease, they don't go to the Guide to Clinical 21 Preventive Services, do they? 22 A. No. 23 MR. WATTLEWORTH: Object to the 24 form. 25 BY MR. LEGER:</p>

<p>1 Q. To your -- you're also an internist; 2 correct? 3 A. No, no. I'm a urologist in general 4 urology only. 5 Q. You're board-certified in urology? 6 A. Correct. 7 Q. And do you have -- in the context of 8 your experience, do general practitioners and 9 family practitioners, in general, turn to the Guide 10 to Clinical Preventive Services to determine the 11 principles on which they base their practices? 12 A. They might. 13 Q. You have no knowledge of it; 14 correct? 15 A. No, I don't. 16 Q. Now, I assume what you read, in 17 particular, was the provision regarding screening 18 for bladder cancer, correct? 19 A. That's correct. 20 Q. And we're not going to spend a lot 21 of time on it, but I just want to refer to you that 22 portion on page 181 -- and this is a copy of what 23 was provided us by your attorneys -- and that's. 24 the -- 25 MR. WATTEWORTH: Do you want him to</p>	<p>122 1 A. No. 2 Q. Would you be interested in seeing 3 any of those documents? 4 A. If I'm told that they're 5 particularly interesting or relevant. 6 Q. By whom? 7 A. It depends. 8 Q. How about if I tell you they are? 9 A. They'd be worth a read. 10 Q. Okay. Have -- in connection with 11 your working in the Engles case, after your 12 deposition, were you requested to do any additional 13 research or study before testifying at trial? 14 A. Was I requested? 15 Q. Yes, sir. 16 A. I don't think I need to be 17 requested. 18 Q. Did you do additional research after 19 your deposition? 20 A. Yes. 21 Q. Okay. In what regard? 22 A. Just general information about 23 bladder cancer and -- 24 Q. Do you expect to do any additional 25 research or study in preparation for testimony at</p>
<p>1 read it or do you want him to -- are you going to 2 ask him about a particular portion? 3 MR. LEGER: Yeah, I'm just going to 4 ask to the -- 5 BY MR. LEGER: 6 Q. Do you disagree with the 7 recommendations under the recommendations in the 8 recommendations square? 9 A. Yes. 10 Q. I'm sorry; Yes, you agree? 11 A. I agree with the recommendations. 12 Q. In connection with your opinion, 13 were you given any internal company documents to 14 review by any of the tobacco companies -- 15 A. No. 16 Q. -- or regarding any of the tobacco 17 companies? 18 A. No. 19 Q. You're a subscriber to the Journal 20 of the American Medical Association? 21 A. I am. 22 Q. Have you followed articles or 23 publications in JAMA regarding the public 24 disclosure of documents in the Minnesota trial and 25 documents regarding Brown &amp; Williamson?</p>	<p>123 125 1 this trial, in the Scott case, than what you've 2 done already? 3 A. If something new comes across my 4 desk, yes, I certainly will. In my general reading 5 of the literature, absolutely. 6 Q. In the context of what we've 7 discussed today, has anything that we've talked 8 about today suggested that you may want to do 9 additional research? 10 A. I wouldn't say -- I couldn't say 11 specifically on what, but, yes, in general, you 12 know, one keeps up with the literature anyway, and 13 now that my interest is piqued by this, I certainly 14 will. I mean, something comes up on bladder tumor 15 or antigens or something, I -- my interest is going 16 to be clearly brought to that. 17 Q. Okay. But, in particular, nothing 18 that we've talked about today has suggested to you 19 that you want to look in any particular subject 20 matter in the context of your testimony; correct? 21 A. No. 22 Q. In Florida, when a medical 23 malpractice case is filed, is it filed in court or 24 is there some type of administrative procedure? 25 A. It has to go through a panel of</p>

<p>1 doctors first, yes.</p> <p>2 Q. Now, did – in the case of the three</p> <p>3 malpractice cases in which you were a defendant,</p> <p>4 did they go beyond the panel of doctors?</p> <p>5 A. Yes.</p> <p>6 Q. And so they were filed in court?</p> <p>7 A. Yes, they were.</p> <p>8 Q. And so they would be public record?</p> <p>9 A. They are.</p> <p>10 Q. What county would they have been</p> <p>11 filed in?</p> <p>12 A. Hillsborough.</p> <p>13 Q. All three of them?</p> <p>14 A. Yes.</p> <p>15 Q. Are you aware of the fact that the</p> <p>16 jury in the Engles case found that smoking causes</p> <p>17 bladder cancer?</p> <p>18 A. Yes.</p> <p>19 Q. Did you testify only regarding</p> <p>20 bladder cancer?</p> <p>21 A. I did.</p> <p>22 Q. Did you disagree with that verdict?</p> <p>23 A. They're not scientists. They're not</p> <p>24 physicians. Far – in the way that they</p> <p>25 interpreted, I guess, you know, I go along with</p>	<p>126</p> <p>1 doesn't cause cancer.</p> <p>2 Q. Okay. You would agree that</p> <p>3 cigarette smoking is a contributing cause to</p> <p>4 cancer –</p> <p>5 A. It's clearly –</p> <p>6 Q. – in the bladder, correct?</p> <p>7 A. – true, yes.</p> <p>8 Q. Would you also agree that cigarette</p> <p>9 smoking can contribute to the development of</p> <p>10 bladder cancer?</p> <p>11 A. Very possibly, yes.</p> <p>12 Q. Have you, in the past, participated</p> <p>13 in any type of a focus group or a mock trial or</p> <p>14 anything of that nature in connection with your</p> <p>15 testimony in either the Engles case or this case?</p> <p>16 A. No.</p> <p>17 Q. Have you been told that you may</p> <p>18 participate in such an activity?</p> <p>19 A. No, I haven't.</p> <p>20 MR. LEGER: I keep trying to think</p> <p>21 of something else. I feel guilty. I think we can</p> <p>22 conclude the deposition at this point.</p> <p>23 MS. DESUE: You – the only other</p> <p>24 thing is whether you would want to offer the</p> <p>25 rest – the rest of his file was basically reports</p>	<p>128</p>
<p>1 them, but as a physician, I know – and as a</p> <p>2 semi-scientist – that that actual causation factor</p> <p>3 has not been – is not satis – not brought to my</p> <p>4 satisfaction that I would accept it and say that</p> <p>5 smoking definitely causes cancer in and of itself.</p> <p>6 Q. And I know – and I'm not going to</p> <p>7 quibble with you – you and the lawyer quibbled</p> <p>8 over the term "reasonable medical certainty." Is</p> <p>9 reasonable medical certainty any different to you</p> <p>10 than reasonable medical probability?</p> <p>11 Q. Well, they are two different words,</p> <p>12 probability and certainty –</p> <p>13 Q. Mm-hmm.</p> <p>14 A. – so they're not equivalent.</p> <p>15 Q. Okay. Would you have an opinion as</p> <p>16 to a reasonable medical probability as to whether</p> <p>17 or not cigarette smoking causes bladder cancer?</p> <p>18 A. As I said about that at that time,</p> <p>19 and I will say now and in the future, there are</p> <p>20 multiple causes for cancer, and at present we</p> <p>21 accept that there is a – what we call a two-hit</p> <p>22 theory in that you start out with some genetic</p> <p>23 predisposition for it, and then some environmental</p> <p>24 exposure causes the expression of that</p> <p>25 susceptibility so that one thing by itself, no,</p>	<p>127</p> <p>1 from various experts, review of Dr. Wiener's</p> <p>2 deposition testimony –</p> <p>3 MR. LEGER: Oh, right.</p> <p>4 MS. DESUE: – if you wanted to</p> <p>5 offer any of those.</p> <p>6 MR. LEGER: Well, yeah. Let me</p> <p>7 spend a couple minutes with you on that.</p> <p>8 BY MR. LEGER:</p> <p>9 Q. Dr. Sartor's report, is there any</p> <p>10 fundamentally that you disagree with in the context</p> <p>11 of Dr. Sartor's report?</p> <p>12 A. This isn't Dr. Sartor's report, is</p> <p>13 it?</p> <p>14 Q. No.</p> <p>15 MR. WATTLEWORTH: Do you have a copy</p> <p>16 of that?</p> <p>17 MR. LEGER: Let's pull it out.</p> <p>18 MS. DESUE: I think it's attached.</p> <p>19 Yeah. Let me just get for you. There we go.</p> <p>20 BY MR. LEGER:</p> <p>21 Q. And I'm going to turn it to the page</p> <p>22 that – page 5 – that refers to bladder cancer in</p> <p>23 particular.</p> <p>24 A. Okay.</p> <p>25 MR. WATTLEWORTH: So your question</p>	<p>129</p>

<p>1 is, is there anything that he disagrees with?</p> <p>2 MR. LEGER: Yes.</p> <p>3 MR. WATTLEWORTH: So, I mean, he —</p> <p>4 do you want to go ahead and read —</p> <p>5 THE DEONENT: Okay.</p> <p>6 MR. WATTLEWORTH: — down through</p> <p>7 that again, if you need to.</p> <p>8 MS. DESUE: I mean, it's all part of</p> <p>9 the record anyway.</p> <p>10 THE DEONENT: No, I don't have any</p> <p>11 problem with that.</p> <p>12 BY MR. LEGER:</p> <p>13 Q. Okay. Thank you. Have you seen</p> <p>14 reports from Dr. Schoenberg and —</p> <p>15 A. I have.</p> <p>16 Q. — Dr. Sartor?</p> <p>17 A. I have.</p> <p>18 Q. Anything you — that you observed</p> <p>19 that you disagreed with in their reports?</p> <p>20 A. Again, I'd have to review them.</p> <p>21 Q. I'll give you both of those.</p> <p>22 MR. WATTLEWORTH: Are you going to</p> <p>23 ask him to review Schoenberg's entire report right</p> <p>24 now?</p> <p>25 MR. LEGER: Yeah. And if you want</p>	<p>130 ..</p> <p>1 skimmed the reports.</p> <p>2 BY MR. LEGER:</p> <p>3 Q. But in any event, your recollection</p> <p>4 is that you did, at one point, study them a little</p> <p>5 bit closer than you just did?</p> <p>6 A. I did.</p> <p>7 Q. And there was no significant</p> <p>8 disagreement that you had with those reports?</p> <p>9 A. That's correct.</p> <p>10 MR. LEGER: I have no further</p> <p>11 questions.</p> <p>12 THE DEONENT: Okay.</p> <p>13 MR. LEGER: Thank you, Doctor.</p> <p>14 THE DEONENT: You're welcome.</p> <p>15 MR. WATTLEWORTH: If we could just</p> <p>16 have a couple of minutes to look over my notes</p> <p>17 and —</p> <p>18 MR. LEGER: Sure.</p> <p>19 MR. WATTLEWORTH: — confer.</p> <p>20 (Discussion off the record.)</p> <p>21 CROSS-EXAMINATION BY MR. WATTLEWORTH:</p> <p>22 Q. Dr. Cockburn, I have just a couple</p> <p>23 of follow-up questions I'd like to ask you.</p> <p>24 Counsel for the plaintiff, a moment ago, asked you</p> <p>25 to look at Dr. Sartor's report, very briefly —</p>
<p>1 to take a break —</p> <p>2 MR. WATTLEWORTH: It's like 10 or 15</p> <p>3 pages long. That's what I asked. Actually, let's</p> <p>4 go off the record for a second.</p> <p>5 MR. LEGER: Let's go off the</p> <p>6 record.</p> <p>7 (Discussion off the record.)</p> <p>8 BY MR. LEGER:</p> <p>9 Q. And just for the record, while we</p> <p>10 were off, counsel for the defendant reminded you</p> <p>11 that these reports were reports that were</p> <p>12 prepared in this litigation on behalf of the</p> <p>13 defendants, and then you reviewed them off —</p> <p>14 A. I have.</p> <p>15 Q. — off the record? Anything</p> <p>16 significantly that you disagree with in these</p> <p>17 reports?</p> <p>18 A. No.</p> <p>19 MR. WATTLEWORTH: If I could just</p> <p>20 let the record reflect that he took a fairly brief</p> <p>21 opportunity to review them, and Dr. Schoenberg's</p> <p>22 report is 10 to 15 pages and it's — you know, the</p> <p>23 minutiae of which he didn't have an opportunity to</p> <p>24 refresh his recollection.</p> <p>25 MR. LEGER: I would agree; he really</p>	<p>131 ..</p> <p>133</p> <p>1 A. Yes.</p> <p>2 Q. — and asked you if there was</p> <p>3 anything in that report with which you disagreed.</p> <p>4 And just to make sure everything's clear on this</p> <p>5 issue, you are aware that Dr. Sartor is advocating,</p> <p>6 along with the other experts for the plaintiffs,</p> <p>7 that a population of smokers in Louisiana are the</p> <p>8 ones who are going to be screened for bladder</p> <p>9 cancer? In other words —</p> <p>10 A. That's correct.</p> <p>11 Q. — they will be screened because</p> <p>12 they are smokers or ex-smokers. Is that your</p> <p>13 understanding of what their —</p> <p>14 A. Yes.</p> <p>15 Q. — approach is?</p> <p>16 A. Yeah.</p> <p>17 Q. Okay. Now, do you agree with that</p> <p>18 proposal?</p> <p>19 A. No, no, and I said so before. Not</p> <p>20 just because they're smokers. I mean, I thought I</p> <p>21 made that point clear, and I didn't pick that up</p> <p>22 again in Dr. Sartor's report. Again, not just</p> <p>23 because they're smokers, but if they had</p> <p>24 hematuria. And hematuria is the defining trigger</p> <p>25 that will then alert the clinician to go and do the</p>

1 other necessary workup.  
2 I don't think that people should be  
3 screened in the way that we've been talking about  
4 screening just because they're smokers. The yield  
5 on that is much, much, much too low to -- it's  
6 certainly not cost effective -- to justify it.

7 Q. And we -- you discussed this a  
8 little bit earlier, but, again, I want to make sure  
9 this is clear, because I'm not sure it was. Is it  
10 your opinion that the urinalysis itself is the  
11 initial screening tool?

12 A. Is the screening tool.

13 Q. Is the screening tool.

14 A. Yes.

15 Q. Okay.

16 A. And when we're talking about  
17 screening, that's what the urinalysis does, is to  
18 screen for those individuals who might be  
19 susceptible to developing some other abnormality,  
20 and cancer is one of them. But I accept that as a  
21 screening tool. None of the others have the lack  
22 of expense, ease of facility of use, and wide  
23 applicability as urinalysis.

24 Q. And after urinalysis, if the person  
25 who is screened has -- is positive for hematuria,

1 blood in the urine, at that point, the other tests  
2 that you would prescribe for that patient --  
3 cytology, cystoscopy, IVP -- those are follow-up  
4 tests --

5 A. Those are follow-up tests --

6 Q. -- to determine --

7 A. -- and they're not screening tests.

8 Q. And you don't -- and that procedure  
9 of beginning with a urinalysis and then follow-up,  
10 depending on what you find -- in other words, if  
11 you find hematuria, then you follow up --

12 A. Right.

13 Q. -- with those three methods -- those  
14 are, again, not dependent on whether you're a  
15 smoker --

16 A. No.

17 Q. -- or an ex-smoker --

18 A. That's correct.

19 Q. -- or a never smoker?

20 A. That's correct.

21 Q. I think you stated earlier, it's  
22 something that -- urinalysis is something that you  
23 should have on a yearly basis as part of your --

24 A. If you've never been a smoker and  
25 you have blood in your urine, you get the same

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1 workup.

2 Q. Okay. We talked earlier -- counsel  
3 for the plaintiff asked you a lot of questions  
4 about NMP-22 as an adjunct to cytology,  
5 cystoscopy. Is there any kind of a consensus in  
6 the medical community as to the appropriateness of  
7 using NMP-22 as an adjunct?

8 A. Yes. I think the consensus now is  
9 that it is not of value to be used in this  
10 context. It has potential, as do several other  
11 tests, but the variability in its detection ability  
12 in terms of its sensitivity, in terms of its  
13 specificity, are too broad to recommend it to be  
14 used in this fashion.

15 As I mentioned before, the most --  
16 the best way that it can be used right now is for  
17 those individuals who have been found to have  
18 bladder cancer and have been treated, and now  
19 you're treating them for follow-up and you want to  
20 decide whether or not I want to do a cystoscopy on  
21 this individual in follow-up for recurrence of  
22 their cancer. That's when the NMP seems to have  
23 better validity in its use. But as an open-ended  
24 screening-type test, it's far, far too insensitive  
25 to be used in that context at this time.

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1 Q. Is it accurate to say, then, that in  
2 the urologic community, it is not the standard of  
3 care --

4 A. No.

5 Q. -- to utilize NMP-22 as a follow-up  
6 device when you've got hematuria in the blood --

7 A. It's --

8 Q. -- following the urinalysis?

9 A. It's not the standard of care for  
10 follow-up for hematuria or for bladder cancer.  
11 It's not the -- it's presently being studied as  
12 such, but it's not the standard of care to be used  
13 at all, in any context, whether just hematuria or  
14 if a patient has defined history of bladder  
15 cancer.

16 It's one of those new things that  
17 has come along, and it's under evaluation. And  
18 possibly within the next five years, we're going to  
19 know more about it or it'll be refined better so  
20 that we can -- it will have greater utility, but  
21 right now, it doesn't.

22 MR. WATTLEWORTH: That's all we've  
23 got.

24 MR. LEGER: Okay. Doctor, I've got  
25 a few more questions.

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<p>1   REDIRECT EXAMINATION BY MR. LEGER:</p> <p>2   Q. Doctor, you provided us with a 3   number of medical articles --</p> <p>4   A. Yes, sir.</p> <p>5   Q. -- and which you indicated you had 6   relied upon in the context of your opinions; 7   correct?</p> <p>8   A. Correct.</p> <p>9   Q. And a number of those reported 10 testing of a number of the diagnostic tools or 11 monitoring tools or screening tools or tests that 12 you spoke about on the second page of your report; 13 correct?</p> <p>14   A. That's correct.</p> <p>15   Q. And those included vascular 16 endothelial growth, PMS, SAT Stat (sic), 17 Telomerase, NMP-22, and the others that you'd 18 suggested; correct?</p> <p>19   A. That's correct.</p> <p>20   Q. Would you agree that, largely, this 21 literature is supportive of the usefulness of those 22 tools in detecting bladder cancer?</p> <p>23   A. No.</p> <p>24   MR. WATTLEWORTH: Are you talking 25 about all those tools?</p>	138	<p>1   hematuria?</p> <p>2   A. No.</p> <p>3   Q. You don't think that it predicts 4   bladder cancer --</p> <p>5   A. No.</p> <p>6   Q. -- in people with hematuria?</p> <p>7   A. No.</p> <p>8   Q. All right. Now, you will recall 9   that my earlier hypothetical had nothing to do with 10 people that already have bladder cancer, correct?</p> <p>11   A. No, then I don't recall that --</p> <p>12   Q. Okay. The record will speak for 13 itself.</p> <p>14   So you also agree, Doctor, that 15 screening is recommended in people who are high 16 risk to exposure to environmental carcinogens; 17 correct?</p> <p>18   A. That's correct.</p> <p>19   Q. And the screening you would 20 suggest -- the initial lining of screening -- would 21 be urinalysis; correct?</p> <p>22   A. That's correct.</p> <p>23   Q. And once screened for hematuria, and 24 a finding of hematuria, there are secondary 25 screening opportunities that you have; correct --</p>	140
<p>1   MR. LEGER: Yes.</p> <p>2   MR. WATTLEWORTH: Okay.</p> <p>3   A. No, no, no. I think what the 4   articles say is that there is an ongoing search for 5   something that would be better than cytology. At 6   the present time, there is none. None are better 7   than cytology. If you take cytology and you 8   compare it against each one of those individually, 9   the cytology is still a better test.</p> <p>10   BY MR. LEGER:</p> <p>11   Q. Now, you've testified that if 12 you take NMP-22 and cytology together --</p> <p>13   A. Yes.</p> <p>14   Q. -- they both complement each other; correct?</p> <p>15   A. You have an adjunctive benefit; you 16 have more information.</p> <p>17   Q. So you would agree, of course, in 18 the context of attempting to diagnose bladder 19 cancer, if you did NMP-22 and cytology together, 20 you have a better predictive potential than using 21 cytology alone; correct?</p> <p>22   A. For people who have already had 23 cancer of the bladder.</p> <p>24   Q. What about people who have</p>	139	<p>1   MR. WATTLEWORTH: Object to the 2 form.</p> <p>3   Q. -- including the use of the 4 cytology?</p> <p>5   MR. WATTLEWORTH: Object to the 6 form.</p> <p>7   A. Well, it's no longer called 8 screening at that point.</p> <p>9   BY MR. LEGER:</p> <p>10   Q. What is it called at that point?</p> <p>11   A. That's called a workup.</p> <p>12   Q. Okay. And what is a workup?</p> <p>13   A. A workup is where you have a defined 14 abnormality and now you're looking for the cause of 15 that abnormality.</p> <p>16   Q. Okay.</p> <p>17   A. So the abnormality is just blood in 18 the urine.</p> <p>19   Q. Okay. So the urinalysis itself is 20 the screen in the population where you haven't 21 defined the abnormality yet; correct?</p> <p>22   A. That's correct.</p> <p>23   Q. Okay. Now you have found an 24 abnormality --</p> <p>25   A. Mm-hmm.</p>	141

<p>1 Q. -- and you're simply trying to --  2 you're trying to limit and differentiate between  3 what disease or illness may be causing the  4 abnormality; correct?  5 A. Or none.  6 Q. Or none, or to exclude --  7 A. Right.  8 Q. -- disease or illness; correct?  9 A. Yeah.  10 Q. Now, do any of these studies that  11 you show -- that you present with your -- in your  12 reference guide suggest that NMP-22 is not  13 effective in attempting to identify the abnormality  14 in hematuria?  15 A. None of them speaks to any of them  16 as being ineffective. It's a relative degree of  17 effectiveness in terms of what you want from a  18 screening test. Okay? A screening test, you want  19 high sensitivity to pick out all of the positives  20 in a population, and you want -- and specificity so  21 that all the positives that you pick out are --  22 have what you're looking for.  23 In that regard, all of those tests  24 show promise. And most of the articles point out  25 that if you combine two of them, then they approach </p>	<p>142</p> <p>1 predictive value of NMP-22?  2 A. Again, it's very variable. Just  3 because it's negative, it doesn't mean that you  4 don't have a tumor.  5 Q. Right.  6 A. And we're --  7 Q. That's true of many tests; correct?  8 A. That's true of many tests, but --  9 Q. Including cytology?  10 A. That's correct.  11 Q. And in any event, the articles speak  12 for themselves --  13 A. That's correct.  14 Q. -- in the context of what they  15 found?  16 A. (Deponent nods head.)  17 Q. The article by Marta  18 Sanchez-Carbayo, Comparative Sensitivity of  19 Urinary -- is it CYRFA 21-1, etc.? -- that's an  20 article provided to you by lawyers for the tobacco  21 companies or is that one you found yourself?  22 A. What's the journal?  23 Q. It's from --  24 A. Is that Journal of Urology?  25 Q. That is Journal of Urology. </p>
<p>1 some of the accuracy of cytology. If you combine  2 NMP-22 with cytokine 33 test, then you have --  3 you approach it. Now you have two tests, so two of  4 those together may equal the one that you're using  5 now. So what we want is something better than  6 cytology.  7 Q. So if you -- and as you testified  8 before, if you combine NMP-22 and cytology, you  9 have a modality that's even better than cytology  10 alone; correct?  11 A. In symptomatic patients, those who have  12 had cancers before that you've treated and you're  13 treating -- you're now looking for recurrence.  14 Q. Okay. You believe that NMP-22 is  15 not effective in identifying the source of  16 abnormality in persons who did not have cancer  17 already?  18 A. No, because that test is only  19 looking for cancer cells, and so it is not as  20 effective as we would like it to be.  21 Q. Okay. And what is the -- or do you  22 know what the positive predictive value of NMP-22  23 is?  24 A. Oh, it's all over the place.  25 Q. Okay. What is the negative </p>	<p>143</p> <p>145</p> <p>1 A. I think that's one of mine.  2 Q. What's the relevance of a high  3 negative predictive value?  4 A. High -- it's a strike against the  5 test. The test is inaccurate in terms of high  6 false negatives.  7 Q. And how does that relate to --  8 sensitivity to detect malignancy?  9 A. Well, that means that the  10 sensitivity is less than desirable.  11 Q. Okay. If the sensitivity is a  12 hundred percent for invasive disease, is that good  13 or is that bad?  14 A. That's good for invasive disease.  15 Q. And if it's 70 percent overall, what  16 does that mean?  17 A. That means that it's very good for  18 invasive disease, very poor for early stage  19 disease.  20 Q. For superficial tumor --  21 A. Or --  22 Q. -- or early stage invasive disease?  23 A. Or early stage invasive disease.  24 Q. Doctor, would you agree that  25 painless hematuria occurs in about 85 percent of </p>

PROSECUTION

<p>1 patients with bladder cancer?</p> <p>2 A. Yes, I would accept that.</p> <p>3 Q. Would you also agree that nearly all</p> <p>4 patients with bladder cancer have at least</p> <p>5 microhematuria?</p> <p>6 A. Yes, sir.</p> <p>7 Q. How much does a urinalysis cost?</p> <p>8 A. Medicare will pay you \$6 for it</p> <p>9 sometimes.</p> <p>10 Q. Will Medicare pay for cytology?</p> <p>11 A. Yes.</p> <p>12 Q. What will they pay?</p> <p>13 A. I don't know. I don't know how much</p> <p>14 of it they will pay. I really don't know.</p> <p>15 Q. About how much does cytology cost?</p> <p>16 A. It's about \$120.</p> <p>17 Q. Would \$40 be a good price for</p> <p>18 cytology?</p> <p>19 MR. WATTEWORTH: Object to the</p> <p>20 form. Are you talking about Medicare</p> <p>21 reimbursement?</p> <p>22 MR. LEGER: I'm talking about cost.</p> <p>23 MR. WATTEWORTH: Oh.</p> <p>24 MR. LEGER: Simply cost.</p> <p>25 MR. WATTEWORTH: Oh, if it cost</p>	<p>146</p> <p>1 A. I shouldn't make a statement about</p> <p>2 this, because I'm totally in the dark as to what</p> <p>3 the costs of cytology are across the board. Some</p> <p>4 places - I'm sure there are places that you can</p> <p>5 get it for less than \$120, so I don't know. \$60,</p> <p>6 \$80. I don't know.</p> <p>7 Q. You would agree that the reason that</p> <p>8 cytology is not - or one of the reasons that</p> <p>9 cytology is not recommended for screening or</p> <p>10 monitoring is the high cost; correct?</p> <p>11 A. We use it for monitoring, but we</p> <p>12 don't use it for screening.</p> <p>13 Q. What's the difference? I guess</p> <p>14 that's what we need to talk - what's the</p> <p>15 difference between monitoring and screening?</p> <p>16 A. Okay. When you have an unknown</p> <p>17 population that you're surveying, that's screening.</p> <p>18 Q. Okay.</p> <p>19 A. When you have a known population</p> <p>20 that has the disease, then you're monitoring them</p> <p>21 for the disease recurrence.</p> <p>22 Q. What about a population that has a</p> <p>23 high risk for the disease?</p> <p>24 A. You're screening.</p> <p>25 Q. Okay. So you consider that you're</p>
<p>1 \$40?</p> <p>2 MR. LEGER: Mm-hmm.</p> <p>3 THE DEPONENT: With the same degree</p> <p>4 of accuracy?</p> <p>5 BY MR. LEGER:</p> <p>6 Q. Is there different types of</p> <p>7 cytology?</p> <p>8 A. Different types of people who are</p> <p>9 reading it, and that's what you're depending on.</p> <p>10 Q. Okay.</p> <p>11 A. And so, if you're going to</p> <p>12 pay someone cheaply, you might not get the best</p> <p>13 person there, so -</p> <p>14 Q. Presumably, you can get volume</p> <p>15 discounts for tests; right?</p> <p>16 A. Presumably.</p> <p>17 Q. You would agree, even in medicine?</p> <p>18 A. Yeah, well, I think the \$120 is</p> <p>19 probably the volume discount.</p> <p>20 Q. Okay. But if you could get it for</p> <p>21 \$40, that would be pretty cost effective; right?</p> <p>22 A. Yeah.</p> <p>23 Q. Assuming everything else?</p> <p>24 A. See, I'm -</p> <p>25 Q. Assuming competency and otherwise?</p>	<p>147</p> <p>1 not monitoring until you've already found some</p> <p>2 evidence of the disease?</p> <p>3 A. That's correct.</p> <p>4 Q. Okay. Well, is there - is that a</p> <p>5 definition that's accepted in the scientific</p> <p>6 literature?</p> <p>7 A. I would think so.</p> <p>8 Q. Is it - would you agree that the</p> <p>9 terms "screening" and "monitoring" are used</p> <p>10 oftentimes -</p> <p>11 A. Interchangeably?</p> <p>12 Q. - interchangeably?</p> <p>13 A. I think inaccurately so, yes.</p> <p>14 Q. Okay. But you would agree,</p> <p>15 generally in the medical profession, it may be</p> <p>16 often used interchangeably - the two terms?</p> <p>17 A. I don't think by doctors, by</p> <p>18 clinicians.</p> <p>19 Q. Okay. Where can we find the</p> <p>20 definition of those two terms?</p> <p>21 A. I don't think you're going to get a</p> <p>22 hard-and-fast one. You know, you monitor someone</p> <p>23 for their heart disease, you monitor their</p> <p>24 hypertension, but if you have an asymptomatic</p> <p>25 population, you're not monitoring it; you're</p>

<p>1 basically just checking to see if they have 2 hypertension. 3 Q. Have the lawyers for the tobacco 4 companies shown you the legal definition of medical 5 monitoring — 6 A. No. 7 Q. — under Louisiana law? 8 A. No. 9 Q. I would like — I'm going to show 10 you that, and I want — I mean — 11 MR. WATTLEWORTH: You're talking 12 about the Bourgeois case? 13 MR. LEGER: The Bourgeois case. 14 MR. WATTLEWORTH: Yeah, that 15 outlines the factors for recovery of medical 16 monitoring. 17 MR. LEGER: Right. 18 BY MR. LEGER: 19 Q. Have you seen the factors in the 20 Bourgeois case in Louisiana? 21 A. I don't know the Bourgeois case. I 22 don't know if I did. 23 MR. WATTLEWORTH: Let's go off the 24 record for a second. 25 (Discussion off the record.)</p>	150	152
<p>1 BY MR. LEGER: 2 Q. Doctor off the record, we 3 discussed — you have been shown — Counsel has 4 indicated that you have been shown the factors, 5 without identifying, apparently, to you the name of 6 the case — 7 A. Yes. 8 Q. — that we consider make up the law 9 of medical monitoring in the state of Louisiana; is 10 that correct? 11 A. — 12 Q. In what way were you shown that? 13 A. Well, I have to tell you, I don't 14 even remember the context in which I was shown it, 15 so — 16 Q. Were you given a piece of paper? 17 A. You're identifying something that I 18 can't place at all in my memory, because you keep 19 mentioning the Bourgeois case, and I don't know it 20 as such. If it was shown to me as the Louisiana 21 medical monitoring statute or whatever, then 22 perhaps I was — I had seen it, but I don't 23 remember it. 24 Q. So that we're very clear, I'm — I 25 am not trying to suggest what you have been shown;</p>	151	153

<p>1 procedures exist that make the early detection of 2 bladder cancer possible; correct?</p> <p>3 A. Yes.</p> <p>4 Q. You also agree that cigarette 5 smoking presents a significant exposure to 6 carcinogens found in cigarette smoke; correct?</p> <p>7 MR. WATTLEWORTH: Object to the 8 form.</p> <p>9 A. Given the volume and duration.</p> <p>10 BY MR. LEGER:</p> <p>11 Q. Okay. You agree that cigarette 12 smoking — it's common, unequivocal medical and 13 scientific opinion that cigarette smoke contains a 14 large number of known carcinogens in humans; is 15 that correct?</p> <p>16 MR. WATTLEWORTH: Object to the 17 form. Argumentative.</p> <p>18 A. That cigarette smoke contains — 19 yes — carcinogens, yes.</p> <p>20 BY MR. LEGER:</p> <p>21 Q. And these carcinogens are in 22 particulate form; correct?</p> <p>23 A. Yes.</p> <p>24 Q. You would agree that a person who 25 smokes cigarettes is at an increased risk of</p>	<p>154</p> <p>1 Q. So you don't agree or believe that 2 five pack years of cigarettes is significant 3 exposure; correct?</p> <p>4 A. Significant for the development of 5 bladder cancer?</p> <p>6 Q. Yes, sir.</p> <p>7 A. It depends on the susceptibility of 8 the individual.</p> <p>9 Q. Okay. And we're talking about 10 individuals in total. We don't know 11 susceptibility, do we?</p> <p>12 A. No, we don't.</p> <p>13 Q. All we know is that approximately 50 14 percent of bladder cancers have been related to 15 smoking cigarettes; correct?</p> <p>16 MR. WATTLEWORTH: Object to the 17 form.</p> <p>18 A. I don't like generalizations like 19 that because it's one factor in an individual's 20 total exposure in his daily life. Is that 21 individual also a truck driver? Does he also work 22 in an industry in which there are other 23 carcinogens? It's hard to say.</p> <p>24 BY MR. LEGER:</p> <p>25 Q. Are you asking me?</p>
<p>155</p> <p>1 contracting bladder cancer and other serious 2 diseases over a person who has never smoked 3 cigarettes; correct?</p> <p>4 MR. WATTLEWORTH: Object to the 5 form. Vague.</p> <p>6 A. Depending on the number of 7 cigarettes per day per year.</p> <p>8 BY MR. LEGER:</p> <p>9 Q. How many cigarettes per day? How 10 many years?</p> <p>11 A. It would seem to me, from what I've 12 read, over 15 cigarettes a day for an extended 13 period of years.</p> <p>14 Q. How many?</p> <p>15 A. Without — I would say it would have 16 to be over ten years.</p> <p>17 Q. Okay. And where do you get that 18 figure from?</p> <p>19 A. I picked it out of my head, based on 20 generalizations that I'd seen before for exposure 21 to tobacco.</p> <p>22 Q. Okay. That's opposed to five pack 23 years of cigarettes? Are you familiar with the 24 term "pack years"?</p> <p>25 A. A pack a day for five years, yeah.</p>	<p>157</p> <p>1 A. Well, I'm saying that that's why 2 that figure is inaccurate.</p> <p>3 Q. Are you questioning the scientific 4 literature?</p> <p>5 A. I'm questioning the interpretation 6 of the scientific literature when based only on one 7 factor.</p> <p>8 Q. Including Campbell's Urology; 9 correct?</p> <p>10 A. When based on only one factor, yes, 11 absolutely.</p> <p>12 Q. But you would agree — and I'm not 13 asking you to base it only on one factor; I'm 14 asking you to consider that the epidemiological 15 data and the conventional scientific thought 16 suggests that cigarette smoking is a factor — a 17 risk factor in 50 percent of bladder cancers.</p> <p>18 MR. WATTLEWORTH: Object to the 19 form.</p> <p>20 BY MR. LEGER:</p> <p>21 Q. Would you agree with that?</p> <p>22 A. Fifty percent of bladder cancers in 23 this country?</p> <p>24 Q. Yes, sir, in the United States of 25 America.</p>

<p>1 A. No —</p> <p>2 Q. You disagree with that?</p> <p>3 A. — no. Absolutely, because</p> <p>4 they're — when you include 50 — when you say 50</p> <p>5 percent of cancers, you're including superficial</p> <p>6 cancers as well as invasive cancers, and it would</p> <p>7 seem to me that superficial cancers are not clearly</p> <p>8 identified — well, I don't even know that. I</p> <p>9 can't even say that.</p> <p>10 Q. Right. And I'm not saying</p> <p>11 anything. I'm just asking you if, one, you agree</p> <p>12 that there is a body of scientific thought that</p> <p>13 suggests that cigarette smoking is a substantial</p> <p>14 risk factor in 50 percent of bladder cancers.</p> <p>15 A. In a substantial amount of bladder</p> <p>16 cancers, yes.</p> <p>17 Q. Okay. Would you agree that a</p> <p>18 cigarette smoker's risk of contracting bladder</p> <p>19 cancer is greater than the risk of contracting</p> <p>20 bladder cancer had he not smoked?</p> <p>21 A. Yes.</p> <p>22 Q. Would you also agree that the risk</p> <p>23 of a cigarette smoker in contracting a serious</p> <p>24 disease, such as bladder cancer, is greater than</p> <p>25 the chance of the members of the public at large of</p>	<p>158</p> <p>1 similar in wording to that document?</p> <p>2 A. I can't say that I remember exactly.</p> <p>3 as such.</p> <p>4 Q. Okay. Do you recall being told that</p> <p>5 these are basically the factors of medical</p> <p>6 monitoring in Louisiana?</p> <p>7 A. No.</p> <p>8 Q. Okay. Just one other thing. You</p> <p>9 talked about, both in your deposition and your</p> <p>10 trial testimony in Engles, and to some very limited</p> <p>11 degree here, that there are a couple of steps in</p> <p>12 the development — a couple or a few steps in the</p> <p>13 development of bladder cancer; correct?</p> <p>14 A. Okay, yes.</p> <p>15 Q. One of those steps requires or</p> <p>16 involves an impact of a carcinogenic substance with</p> <p>17 the cells of the bladder; is that correct?</p> <p>18 A. That's correct.</p> <p>19 Q. And is it — would you agree that it</p> <p>20 is the general agreement in the scientific</p> <p>21 community regarding bladder cancer that the impact</p> <p>22 of the carcinogen on the epithelium of the bladder</p> <p>23 is a significant event in the development of</p> <p>24 bladder cancer?</p> <p>25 MR. WATTLEWORTH: Object to the</p>
<p>1 developing a disease, including nonsmokers?</p> <p>2 MR. WATTLEWORTH: Object to the</p> <p>3 form.</p> <p>4 A. Yes.</p> <p>5 BY MR. LEGER:</p> <p>6 Q. Would you agree that there is a</p> <p>7 demonstrated clinical value in the early detection</p> <p>8 of bladder cancer?</p> <p>9 A. Yes.</p> <p>10 MR. LEGER: I don't have any further</p> <p>11 questions.</p> <p>12 MS. WIMBERLY: Just one minute,</p> <p>13 Walter.</p> <p>14 MR. LEGER: Well, actually, I do.</p> <p>15 BY MR. LEGER:</p> <p>16 Q. I just want to — just one question,</p> <p>17 and the question is yes or no. Is — I'm showing</p> <p>18 you a document, which I have produced, which I</p> <p>19 believe is a summary of the factors of Bourgeois,</p> <p>20 and which I think counsel has agreed basically is</p> <p>21 word for word out of the — for what it is, and</p> <p>22 just ask you if you have seen a document which</p> <p>23 outlines those factors in identical wording.</p> <p>24 A. I may have. I don't remember.</p> <p>25 Q. You've seen a document that is</p>	<p>159</p> <p>161</p> <p>1 form.</p> <p>2 BY MR. LEGER:</p> <p>3 Q. Assuming that you eventually find</p> <p>4 bladder cancer.</p> <p>5 A. Yes.</p> <p>6 Q. I understand carcinogens can impact</p> <p>7 the epithelium and never get — you never get</p> <p>8 bladder cancer; right?</p> <p>9 A. That's correct.</p> <p>10 Q. Assuming there is — you say that</p> <p>11 there has to be some earlier event to the</p> <p>12 development of the carcinogen in order for bladder</p> <p>13 cancer to develop; right?</p> <p>14 A. That's correct.</p> <p>15 Q. Something else had to have happened</p> <p>16 first, maybe a genetic predisposition, some other</p> <p>17 impact or insult or trauma; correct?</p> <p>18 A. Right; that's correct.</p> <p>19 Q. And then eventually a carcinogen</p> <p>20 impacts the walls of the epithelium; correct?</p> <p>21 A. That's correct.</p> <p>22 Q. And then there may be other events</p> <p>23 or factors, but — and then you end up with bladder</p> <p>24 cancer; correct?</p> <p>25 A. That's correct.</p>

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<p>1           MR. LEGER: No further questions. 2           MS. WIMBERLY: One minute, Walter. 3           THE VIDEOGRAPHER: Do you want to go 4   off the record? 5           MR. WATTLEWORTH: Just for a second, 6   yes. 7           (Discussion off the record.) 8           MR. WATTLEWORTH: We have no further 9   questions, but I would like to reserve the right 10   for him to read and sign his deposition. 11           MR. LEGER: Oh, absolutely. 12 13           (Deposition adjourned at 1:05 p.m.) 14 15 16 17 18 19 20 21 22 23 24 25</p>	<p>162</p> <p>1           C E R T I F I C A T E 2 3           I, Cynthia L. Varney, a Shorthand Reporter 4   and Notary Public of the State of Florida, do 5   hereby certify that prior to the commencement of 6   the examination, the witness was sworn by me to 7   testify the truth, the whole truth, and nothing but 8   the truth. 9           I do further certify that the foregoing is 10   a true and accurate transcript of the testimony as 11   taken stenographically by and before me at the 12   time, place, and on the date hereinbefore set 13   forth. 14           I do further certify that I am neither of 15   counsel nor attorney for any party in this action 16   and that I am not interested in the event nor 17   outcome of this litigation. 18 19 20 21           Notary Public of the State of Florida 22           Florida Commission No. CC929457 23           Expires: 4/19/04 24 25</p> <p>163</p> <p>1           JURAT 2           I, ALDEN E. COLEBURN, M.D., do 3   hereby certify that I have read the foregoing 4   transcript of my testimony, taken on October 26, 5   2000, and have signed it subject to the following 6   changes: 7   PAGE   LINE   CORRECTION 8   _____ 9   _____ 10   _____ 11   _____ 12   _____ 13   _____ 14   _____ 15   _____ 16   _____ 17   _____ 18 19 20   DATE: 21 22   Sworn and subscribed to before me on this   day of 23 24 25   NOTARY PUBLIC</p>
<p>42 (Pages 162 to 164)</p> <p>VERITEXT/NEW JERSEY REPORTING (973) 992-4111</p>	

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